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The University of Alberta

Bereavement Home Visiting:
Public Health Nurses' Perceptions

by

Marianne Stewart

A Thesis

Submitted To The Faculty of Graduate Studies and Research

In Partial Fulfillment of the Requirements

For The Degree of Master of Health Services

Administration

Department of Health Services Administration

And Community Medicine

Edmonton, Alberta
Spring, 1987

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled Bereavement Home Visiting: Public Health Nurses' Perceptions submitted by Marianne Stewart in partial fulfillment of the requirements for the degree of Master of Health Services Administration.

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Date: March 27/87

ABSTRACT

The underlying objective in this study was to describe which factors public health nurses perceive as facilitating or impeding their carrying out effective bereavement home visits. The need for the study is two-fold: first, there is very limited literature in this area; and second, the provision of information about such perceptions is a necessary step in bereavement program planning and evaluation.

The approach taken in this study was that of a descriptive, comparative survey, entailing two study populations in an urban health department: 78 public health nurses (PHNs) and 11 public health nursing supervisors. Survey questionnaires, constructed based on the investigator's experience and her literature review, were subjected to content validation by a panel of experts and were pilot tested. There was a 96.6% response rate from the PHNs and 100% from the supervisors.

Three constructs identified as being central to bereavement home visiting: perception of skill, attitude towards unexpected death, and fundamentals prerequisite to bereavement home visiting. Each of these constructs was characterized by a distinctive combination of knowledge, skill, and/or affect.

Of these three constructs, the key finding in this study was that PHNs' attitudes toward unexpected death was the greatest impediment in effective bereavement home visiting. It was concluded that the other two factors were related to any type of home visit that PHNs might carry out.

Examination of the raw data indicated that the PHNs' experience, completion of a values clarification inservice program and personal experience with bereavement influenced their perceptions of the adequacy of their specific skills, knowledge, and affect. There was a discrepancy between the priority the PHNs felt should be given to the bereavement program (high) and the priority they actually gave to the program (low). Lack of time, budget, and staff resources were cited most often as the reasons for the discrepancy. The majority of the PHNs, and all of the supervisors, indicated that clients benefitted from the bereavement visits.

To the extent that the PHNs and supervisors in this study are representative, nursing administrators and educators should, at minimum, endeavor to find ways and means of helping PHNs': (1) to recognize unexpected death as an impediment in bereavement home visiting; (2) to understand the complexities of this type of visit, and; (3) to develop strategies to better cope with bereavement involving unexpected death.

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CHAPTER I

INTRODUCTION

The Research Question: What? and Why?

What factors do public health nurses perceive as constituting impediments and facilitators in making effective bereavement follow-up visits?

Public health agencies typically provide services and programs designed to protect and improve the health of individuals and the community. Bereavement following the death of a significant person can constitute a crisis and can put individuals and families at risk of ill health. The intent of public health bereavement follow-up programs is to facilitate the successful resolution of such crises. In public health agencies that provide bereavement follow-up programs, nurses are typically the personnel most involved in providing this service. As a preliminary step to investigating the impact of a bereavement follow-up service, an exploration was made of public health nurses' perceptions of the factors that facilitate and impede their ability to provide such a service. Attention is now drawn to the four specific research questions underlying this study.

Specific Research Questions

1) Which factors do public health nurses (PHNs) perceive as facilitating or impeding their carrying out effective bereavement follow-up visits?

2) What are the relationships among the factors perceived by the PHNs and specific selected demographic characteristics predictive of that group?

3) Which factors do the public health nursing supervisors' perceive as facilitating or impeding PHNs carrying out effective bereavement follow-up visits?

4) What are the relationships among the factors perceived by the PHNs and the factors perceived by the public health nursing supervisors?

Need for the Study: Theoretical Significance

The literature provides convincing evidence that bereavement is a life crisis/psychosocial transition state that stresses individuals and

families to the extent that health can be threatened. (Parkes, 1972; Davies, 1986; Clayton, 1974). Some authors suggest that preventive intervention is helpful in reducing the stress from bereavement and thus reduces the threat to health (Vachon, 1980; Constantino, 1986). However, there is a paucity of literature regarding intervention and its effectiveness, and the few findings that are reported are far from convincing, and are often inconclusive and controversial. In general, the studies to date have involved questionable sampling techniques and designs, resulting in findings that are not sufficiently reliable to justify the conclusion that intervention programs are effective.

There is also very limited literature concerning empirical evidence of public health nurses' perceptions of factors that impede and facilitate their functioning in bereavement programs. There is, however, some research that reports relationships between nurses' attitudes and perceptions of their educational needs. Stover and White (1984), in a study of oncology nurses, reported high correlations between perceived educational needs and aspects of the nurses' role with which the nurses felt most uncomfortable. On the basis of their research the authors developed content for in-service programs that they reasoned would meet important and relevant needs of the oncology nurses for their practice.

Central Assumption and Theoretical Underpinnings

The major assumption underlying this research is rooted in Change Theory. Kurt Lewin, a social psychologist, is best known for his "field theory" and specifically for his extensive work on motivation and its relationship to changing behaviour. His motivational concepts center on purposes that underlie behaviour, and the goals toward, or away from, which behaviour is directed (Lewin, 1939). He presupposes that (a system is in) a state of tension exists within a person whenever a psychological need or an intention is present. Tension is released when the need or intention is fulfilled. It is important to understand the relationship between this state of tension and factors in a person's psychological environment. Tension may be related to a positive activity region in the psychological environment which is perceived as tension reducing or a negative activity region which is perceived as increasing tension. In order for change to take place, tension must first exist. Then, those factors which reduce tension or impede the reduction must be examined. Lewin attempted to develop a geometry which would represent a person's conception of the means-end structure which he called "hodological space". A person will be more likely to change behaviours, or move towards a goal, if the factors that facilitate that movement are increased and/or the factors that impede that movement are decreased (Deutsch and Krauss, 1965; Stinson, 1970). Such theory is relevant to the information that was elicited from the questionnaire used in this study. The public health nurses

identified factors that are barriers or facilitators in carrying out bereavement home visits. Such information would be useful in helping service and educational personnel to develop an educational program aimed at facilitating behaviour change.

Practical Importance

Past studies have not demonstrated unequivocally the value of bereavement intervention. In this researcher's experience, public health nurses involved in bereavement home visiting view the service as valuable. However, the nurses express a wide variety of feelings and concerns about the effectiveness of their interventions for clients, and whether or not they competently carry out the visits. The findings of a study that surveyed parents' perceptions of support after the death of a child (Segal et al., 1986) appear to support the premise that there is variation in the perceived helpfulness of public health nurses' interventions. Nurses who checked back periodically with the family over several months or linked the family with others who had had a similar experience were perceived as helpful. Nurses who appeared to avoid the family or who offered no support or information were perceived as exhibiting harmful behaviour.

It was beyond the scope of this study to conduct a comprehensive evaluation of a bereavement home visiting program. However, the provision of information about nurses' perceptions is a necessary step in the evaluation process and can provide useful base-line information for planning educational interventions.

In addition, as supervisors are viewed as influential in supporting their staff in accomplishing program objectives, it is important to compare supervisors' perceptions of factors with the perceptions of public health nurses and identify congruence, or the lack thereof. This can be used as a basis for exploring the reduction of barriers and strengthening the facilitating factors related to bereavement visiting.

In summary, the intent in this study is to provide information which could potentially form part of the base useful in developing an in-service training program designed to enhance those factors that facilitate and reduce those factors that impede public health nurses carrying out bereavement visits and, ultimately, to provide information for use in bereavement program planning and evaluation.

Definitions

Bereavement: "Loss experienced due to the death of a person" (Liebermann, 1982).

Grief: "Feelings accompanying loss" (Liebermann, 1982).

Public Health Nurse:[1] Refers to a professional nurse working in a generalized program who focuses her attention on health promotion needs

1. As all of the population in this study was female, the feminine gender is used exclusively throughout this report.

and disease prevention in people throughout their life span. In collaboration with the client and other health workers, the nurse combines a knowledge of community health practices, problems and resources, and the nursing process. She assists that individual, family, and community to assume responsibility for sound health practices and to achieve an optimum state of health and self-reliance (E.B.H. Manual of Philosophy, Goals and Objectives, 1985).

Public Health Agency: A local health authority that is characterized by being a publicly funded government agency mandated under the public health act, and whose primary focus is promotion of health and prevention of disease.

Perceptions: Conclusions based on feelings and assumptions rather than fact.

Health Centre: For the purposes of this study, a health centre refers to one of eleven regional public health centres within the Edmonton Board of Health region. Health centres service the population within their boundaries and are staffed by a regional supervisor and public health staff nurses, other professional staff, and administrative support staff.

Values, Attitudes, and Practice (VAP) Inservice Program: An inservice education program for public health nurses designed to allow for expanded opportunity in three specific areas: 1) adopting a common philosophy of

public health nursing; 2) becoming familiar with a particular framework in order to understand selected preclinical skills universally required by nurses; and 3) being able to practice the application of the acquired skills.

Comfort Level: The degree to which the public health nurse feels personally at ease when making bereavement visits.

Limitations

1) The findings are limited to the population of public health nurses under study. Public health programs and in-service education programs vary greatly from one agency to another, thus precluding generalizability.

2) The study findings are further limited to public health nurses working in a generalized program in the agency in which the study is conducted, not to all nurses in that agency.

3) The factors under investigation pertain to bereavement visits to adults, specifically excluding visits to bereaved children.

4) The findings are based on the nurses' perceptions, and do not extend to job performance and/or self-expectations of public health nurses and supervisors. In addition, it was beyond the scope of this study to include the perceptions of clients.

The remainder of this report is organized as four additional chapters: highlights of the literature are reviewed in Chapter Two; the study design and methodology is outlined in Chapter Three. The findings and discussion are reported in Chapter Four, followed by the conclusions and recommendations in Chapter Five.

CHAPTER II

LITERATURE REVIEW

Introduction

There is a plethora of literature which describes currently held knowledge about bereavement. In contrast, the literature addressing important skills and attitudes, as well as factors that impede and facilitate making bereavement follow-up visits is scanty. Literature directed at public health nursing follow-up visits is particularly limited.

In this chapter, literature concerning the factors considered by experts in the field to facilitate or impede bereavement visiting, as well as the relationship of these factors to the demographic variables used in this survey are reviewed. Highlights are presented describing the relationship between cognitive, behavioural, and affective thought and perceptions. In addition, problems regarding the reliability and validity of data collected on subjects' perceptions and feelings are described, as is the literature on the qualitative approach used in this study for purposes of content analysis.

Knowledge

The knowledge that is considered essential for making effective bereavement visits can be categorized into four groups: (1) normal bereavement process (Baro, et al., 1986; Kubler-Ross, 1969; Liebermann, 1982); this includes descriptions of stages and types of grief, commonly experienced feelings, and physical and psychological changes; (2) signs and symptoms of resolved/unresolved grief (Engel, 1977; Ruben, 1984; Whelan, 1985); (3) risk factors in the bereaved (Hogstel, 1985; Maddison & Walker, 1967; Raphael & Maddison, 1976); this category delineates those factors which could render an individual's health to be at risk following bereavement (e.g., lack of social support); and (4) factors that lead to "better" outcomes following bereavement. (Vachon, 1976; Dimond, 1981). This category delineates those factors that reduce the risk to an individual's health following bereavement (e.g., excellent coping skills).

Skills and Attitudes

There is a general paucity of literature aimed at the discussion of skills and attitudes important for helping professionals to have in order to be effective in bereavement intervention. The information available is descriptive in nature and flows from the various authors' often extensive experience with the bereaved. Some of the important skills and attitudes include: listening skills, communication/counselling skills, aiding the bereaved in communicating their feelings and expressing emotions,

observation skills, health assessment skills, teaching skills (e.g., explanation of grief process), understanding, accepting, and empathetic behaviours (Brown, 1982; Cameron, 1980; Vachon, 1979; Cundey, 1981).

Factors That Facilitate

Many authors agree that it is important to "know about" the commonly understood and accepted knowledge of bereavement including process, stages, common signs and symptoms, risk factors, and common physical and psychological manifestations (Reeves, 1984; Woodward, 1984; Leibermann, 1982; Harrington, 1982; Reed, 1981; Baro, et al., 1986). Several authors describe specific characteristics that facilitate making bereavement visits (Reeves, 1984; Woodward, 1984; Cundey, 1981). Particularly important are flexibility, the ability to listen, and what Reeves calls being a "responder" as opposed to a "reactor". A responder always considers the ramifications of their reaction and then determines the type of response that will be most helpful.

Some skills are cited in the literature as being particularly important (Penson, 1979; Reeves, 1984; Woodward, 1984). The "checking-out skill" helps the public health nurse determine how to approach the bereaved at a given time and moment. The "emotional safety skill" allows the public health nurse to be emotionally in touch with the bereaved but helps her to maintain a balance between under and over involvement. Communication skills in general are very important in bereavement counselling. Rogers

and Vachon (1975) specifically point to personal experience with bereavement as being helpful as they maintain it allows for optimum empathy and self-disclosure.

Finally, there is general agreement in the literature that it is important to confront one's own feelings and fears about loss, to have the opportunity to discuss them, and to develop one's own philosophy about life and death, as one's own philosophy and attitudes affect interaction with the bereaved (Whelan, 1985; Cundey, 1981; Reeves, 1984; Alexander and Kiely, 1986).

Factors That Impede

An individual's socialization regarding bereavement may impede the ability to deal with death. Thus, in the case of public health nurses, their socialization regarding death may impede their ability to carry out bereavement visits. Fulton and Langton (1964) suggest that our society teaches avoidance of death and dying. The use of humor and euphemisms about death are seen as a manifestation of society's general reluctance to accept its inevitability. Western society expects a stoic acceptance of death; also, in most societies in the Western World, the expression of grief is severely limited as to time and place. Reeves (1984) suggests examining how one's parents grieved as she maintains that this will determine how one feels about death and dying. More broadly speaking, cultural and religious

norms largely dictate how grief and bereavement are perceived (Folk & Nie, 1959). Some cultures are accepting and expect open manifestations of grief while others expect stoic tolerance.

Whether or not the public health nurse perceives grief as a "disease" may color perceptions of what is normal or abnormal (Fulton & Langton, 1964). The healthy nature of pain and its manifestations, as well as expression of other intense emotions, all of which may be "normal" during bereavement may be viewed as abnormal by public health nurses if they perceive grief as a "disease".

Relationships Between Substantive Factors and Demographic Variables

To date, researchers have not addressed relationships among demographic variables and factors that impede or facilitate bereavement visiting specifically, but there is literature on relationships among demographic variables and attitudes towards death and dying.

Lester, Getty, and Kneisel (1974) compared attitudes about death among undergraduates, graduate nursing students, and nursing faculty at a New York State university school of nursing, and found that generally, fear of death and dying decreased with increased academic preparation. Yeawort, Kapp, and Winget (1974) compared the responses of freshmen and seniors in a baccalaureate nursing program to a questionnaire on

"Understanding the Dying Person and His Family". The seniors showed greater acceptance of feelings, more open communications and broader flexibility in their responses than freshmen. Caty and Tomlyn (1984) found a two-day death education seminar provided third year baccalaureate nursing students with more open and flexible attitudes.

The findings of studies investigating potential relationships between attitudes about death and experience with bereavement suggest the relationship is ambiguous. Rogers and Vachon (1975) and Whelan (1985) report that direct personal experience with bereavement influences how well a person is able to understand and empathize with someone's grief. They see personal experience with bereavement as a helping influence in bereavement home visiting. Pearlman, Stosky and Dominick (1969) and Shusterman and Sechrest (1973) investigated relationships among attitudes toward death and nursing personnel's experience with bereavement. Pearlman, et al. found that subjects with more experience with death (personal and professional) felt more uneasy with dying patients than those with less experience. Shusterman and Sechrest found no significant relationship to any aspect of nurses' death anxiety and death experience. Age, however, was a significant confounding factor. As age and experience increased, anxiety about death and dying decreased.

Benner (1984) discusses the "meaning of experience". Experience is defined as the "refinement of preconceived notions and theory through

encounters with many actual practical situations" (p. 36). As experience and mastery of skills increase behaviour evolves from rule governed, task oriented behaviour to behaviour exhibiting an initiative grasp, and skills are transformed in such a way that the nurse "feels" or "just knows" what to do. Benner's work suggests that as experience with bereavement visiting increases, the nurses should feel more capable and competent in doing these visits. Popoff (1975) and Stoller (1980) examin relationships between attitudes towards death and dying and contact with dying patients. Popoff found no significant relationship between positive attitudes towards death and dying and frequent contact with dying patients. Indeed Stoller found that as years of experience increased, nurses' ability to cope with dying patients decreased.

Cundey (1981) and Whelan (1985) stress that it is important for nurses to confront their own feelings about death and dying, and to understand their behaviour and defenses in response to loss if they are to be effective in bereavement intervention. Quint (1967) examines nursing students' encounters with dying patients in the course of their education. She found that their teachers' efforts to teach the nursing care of dying patients were greatly influenced by the teachers' personal experience with death. Those who could openly talk to students about this type of care were those who had come to terms with their own concerns about death. Discussion is now centered on relationships between the cognitive, behavioural, and affective domains.

Relationships Between The Cognitive, Behavioural, and Affective Domains

It is evident from reviewing the literature that there are three distinct domains within bereavement visiting: cognitive, behavioural, and affective.

The cognitive and behavioural content in bereavement visits is well documented in the literature and it is clear that adequate knowledge and skills are seen as being a prerequisite to making effective bereavement visits. However, it is important to note that this content has not been systematically described and scientifically tested. Thus it falls short of constituting a sound basis for determining the universe of specific knowledge components and skills that are necessary and sufficient for public health nurses to have in order to carry out effective bereavement visits.

The affective domain plays a particularly influential part in determining what factors help or hinder the public health nurse in carrying out bereavement visits. Human behaviour cannot be neatly separated into the three domains. In fact, some authors (Bloom and Broder, 1985; Johnson, 1955) demonstrated that cognition and affect can never be completely separated. As a result, a public health nurse may have a very high degree of cognitive understanding (i.e., knowlege of bereavement) and

yet her affective experience with bereavement visiting may inhibit her from carrying out an adequate visit. Conversely, a public health nurse may have a very low cognitive understanding and yet be highly motivated and appropriately sensitized to do bereavement visiting as a result of her particular experience. A high degree of cognitive achievement as well as a high level of interest and motivation may also be the case. Krathwolh, et al. (1956) suggests that all three of these situations are not only theoretically possible but actually are represented among public health nurses undertaking such visits.

The factors listed in the affective domain, then, are particularly important to identify in order to facilitate an understanding of the relationship of the affective domain with the cognitive and behavioural domains. Depending on how public health nurses feel about bereavement visiting, they may be comfortable, or uncomfortable, when they make bereavement follow-up visits.

Reliability of Information Elicited on Perceptions

Kerlinger (1973) uses a variety of synonyms to describe reliability -- dependability, stability, consistency, and accuracy. He defines reliability as the "relative absence of errors of measurement, or the accuracy and precision of a measuring instrument" (p. 442).

Two key models of reliability are relevant to this study.

1) Stability or consistency over time: this interpretation assumes the administration of a test to individuals more than once. Over time, the measure will tend to yield the same interpretive results, if the test is reliable.

2) Internal consistency: this interpretation is concerned with the homogeneity of the test items (i.e., consistency among items intended to measure the same attribute or construct). If the test items which are intended to measure the same trait were divided into subsets, the subset measures should produce the same interpretive results if internal consistency (reliability) is high.

The model of internal consistency interpretation was the most appropriate model of reliability for this study because of the type of information elicited from the questionnaire. According to Fox (1966), when using questionnaire techniques to elicit information, it is generally assumed by the researcher that respondents are answering the questions honestly and accurately. However, if the information desired is sensitive in nature, the respondents may not answer accurately and honestly. As a result, the reliability of such information, over time, may be weakened, as compared with the reliability obtained from responses to questions that are strictly factual in nature. To expand further, Fox (1966) describes three types of questions that can be asked: 1) Superficial: The information

sought in this instance is fixed, highly specific, and unchanging with little personal overtone. Respondents will most likely freely give this type of information accurately and honestly; 2) Subsurface: The information sought in this case is not fixed and unchanging, but can change for each respondent often over a brief period of time because it involves opinion, judgement and perceptions. Respondents may feel less free to respond accurately and honestly; and 3) Depth: The information sought in this case is deeply personal and very changeable and usually respondents are unwilling to answer these types of questions.

In this study, the subjects were asked to respond to subsurface questions aimed at measuring their perceptions of factors that impede and facilitate making bereavement follow-up visits. Such data are subject to change and tend to be more personal in nature than superficial questions, features that threaten the reliability of data over time. The reliability coefficient of a test/re-test would, therefore, be expected to be low. However, the internal consistency of these data could be pursued with the expectation of a satisfactory reliability coefficient.

Validity of Information Elicited on Perceptions

Linquist (1942) defines validity as "the accuracy with which a test measures that which it is intended to measure, or as the degree to which it approaches infallibility in measuring what it purports to measure" (p. 213).

Cronbach and Meehl (1955) defined three major categories of validity: content; criterion-oriented; and construct. Content validity refers to the degree to which the sample of content of the measure is representative of the universe of possible content of this measure (Cronbach and Meehl, 1955, p. 282). For this study, the universe of content of bereavement visits was unknown. Criterion-oriented validity involves predicting the measure of the instrument against some outside criterion, or, in this case, some other established measure of factors that facilitate or impede carrying out bereavement visits (Cronbach and Meehl, 1955, p. 282). Again, in this study, there was no criterion measure. Construct validity is appropriate when a test is used to interpret measures intended to tap non-operational attributes, i.e., constructs (Cronbach and Meehl, 1955, p. 282). A construct is a proposed attribute, in this case, a factor that facilitates or impedes public health nurses carrying out bereavement visits.

Since this study attempted to determine what factors were perceived to facilitate or inhibit carrying out bereavement visits, the validity model of choice was construct. However, it was necessary to first establish some degree of confidence in the appropriateness of the factors which the nurses rated. Thus, models of face validity and content validity were appropriate for this purpose.

Content Analysis Methodology

Field and Morse (1985) refer to five types of content analysis: thematic; static; phase; latent; and manifest. Thematic analysis was

appropriate for this study, which involved developing themes, categories, constructs, etc. Categories from the content analysis are developed following a sequence of steps:

1) Derive categories from emerging commonalities from transcripts or questionnaires.

2) Achieve category saturation so that as many categories are developed as is possible. Eventually the researcher may reduce the resulting categories by making them more specific or more general.

3) Develop definitions based on the properties inherent in any one category. The definitions will outline the criteria that will be used for pulling further content into categories.

4) Note, describe, and develop links between categories.

5) Connect the categories with existing theory.

This method used for the qualitative analysis proved to be acceptable for deriving clear and concise content categories.

The information from the literature review provided the theoretical underpinnings for this research, as well as valuable content that was incorporated into the questionnaire. In addition, the review provided invaluable information for making research methodology decisions. The next chapter presents the research design and methodology.

CHAPTER III

RESEARCH DESIGN

Introduction

In this study, public health nurses' perceptions of the factors that impede and facilitate carrying out bereavement home visits was investigated using a survey approach. There were two major phases: the development of a questionnaire (which included a pilot run of the questionnaire to establish its reliability and validity), and the survey of the study populations.

Study Populations

There were two study populations: 1) Seventy-eight public health nurses working in a generalized program, all of whom were staff nurses employed within a local health authority; and 2) eleven public health nursing regional supervisors who were responsible for the supervision of the nurses and the day-to-day management of the generalized programs.

Questionnaire Development

Introduction

It was reasonable to postulate, given the information obtained from the literature review, that the unknown factors involved in carrying out bereavement visits would be of three distinct types: cognitive, behavioural, and affective aspects of bereavement visits. Thus, it was postulated a priori that the public health nurses would identify these unknown factors or constructs as postulated. The researchers labelled these constructs as understanding, assisting and copying reflecting the three domains of bereavement visits. The structure and content of the questionnaire was developed assuming these postulated factors, i.e., the questionnaire was composed of as many closed-ended, fixed choice questions as possible addressing the three domains. Content and face validity procedures were used to establish some degree of confidence in the appropriateness of the content. In addition, the questionnaire included some open-ended questions. Bereavement visiting is a relatively new phenomenon about which little is written and thus, it was considered important to allow the nurses to make comments following selected questions so that as much information as possible could be gathered.

Content Validity

The content of the questionnaire was derived from two specific sources -- literature on bereavement, and the findings from an exploratory

study, "Bereavement Home Visiting Survey" (Edmonton Board of Health, 1980) which among other factors determined nurses' perceptions of their educational and support needs in the area of bereavement home visiting. The content identified from the literature for the questionnaire used in this study was gleaned from descriptive studies and published narratives by practitioners with extensive experience in bereavement home visiting. However, evident disagreement existed in these sources as to the nature and number of factors which would impact on the public health nurses' ability to do bereavement visits.

Thus, a comprehensive collated listing of the cognitive, affective, and behavioural factors identified as influencing bereavement visits were developed into one questionnaire and this was then submitted for review and content validation to five experts with practical experience in bereavement home visiting and specific expertise in the area of bereavement (Appendix I). Via letter (Appendix II), these individuals were asked to scrutinize each and all items for their inclusiveness and clarity as factors important to making effective bereavement follow-up home visits (Appendix III). A factor in bereavement home visiting was considered for inclusion (i.e., defined to be content valid) if at least four out of the five experts agreed that it was part of the essential content in carrying out effective visits. While the number of validators was relatively small, findings from the literature has indicated that this level of consensus is regarded as acceptable for content validation (Hayes, 1974). In addition to the above, comments and suggestions for improving the clarity of certain

items were incorporated when the suggested modification was repeatedly noted across validators and when the suggestion was self-evident as an improvement.

The review by the five validators resulted in all items being defined as related to important factors in bereavement visiting. However, five items did require modification for clarity. Further, the content experts also identified an additional five factors. These were incorporated in the test form of the questionnaire used in the pilot study (Appendix IV). Further validation could not be pursued for the following reasons:

1) The knowledge, skill, and attitudes content necessary and sufficient to carry out an effective bereavement home visit have not been scientifically and systematically established. The universe is at best ambiguous and at worst unknown, thus precluding a systematic delineation of factors.

2) Lack of an established definition of what constitutes a recognized content expert in the area of bereavement home visiting hinders construction of a validation committee.

3) The phenomenon in question (i.e., perceptions of factors involved in bereavement home visiting) does not lend itself to criterion-based validation procedures.

Pilot Study

Method

Pilot Sample

The pilot sample surveyed was comprised of eleven public health nurses, one randomly selected from each clinic; all were currently employed by the Edmonton Board of Health and working in a generalized program.

Data Collection and Response Rate

One week prior to the distribution of the test questionnaire, a letter was sent to the pilot study subjects explaining the intent of the study, ethical considerations and details concerning receipt of the questionnaire (Appendix V).

A questionnaire was then sent to these subjects through the Agency's courier system. Each questionnaire was coded to track the number of questionnaires referenced and the specific health centre in which the subject was employed. The coding was done by a third party so the respondents could not be identified by the researcher. The respondents were asked to return the questionnaire within one week's time in a self-addressed, stamped envelope attached to the questionnaire. Ten out of the

eleven questionnaires were returned on time. The eleventh response was received after the analysis was completed. There was an even distribution of respondents with respect to all the demographic factors with one exception -- all ten respondents had made at least one bereavement visit.

Analysis Procedures

Face validity procedures were done to test the appropriateness of the factors established a priori. An alpha coefficient was computed to determine the internal consistency of each of the subsets of questions related to cognitive, behavioural, and affective factors as well as for the test as a whole. In addition, inter-judge consistency in rating the open-ended questions was also established. Frequency tables were generated to obtain an indication of the percentage of responses in any one category as well as a breakdown of the demographic characteristics.

Results

Face validity of an instrument is highly desirable in order to obtain a high degree of acceptance from respondents as well as from those responsible for using the results. To establish face validity, respondents were asked if items adn the questionnaire as a whole were clear, reasonable, and relevant from their perspectives. The critique of the questionnaire by respondents was done using a structured form attached to the questionnaire (Appendix VI). As mentioned above, all but one of the respondents completed the form. It is apparent that for the most part the

questionnaire had acceptable face validity. In addition, the respondents said they were able to answer the questions quite easily and within a reasonable period of time. However, the respondents did identify seven additional content items (three behavioural and four affective factors) and these were incorporated into the final form of the questionnaire.

The alpha coefficients for the three separate domains as well as for the total test were as follows:

Cognitive	.922
Behavioural	.92
Affective	.916
Total Test	.9

The size of these coefficients was not necessarily desirable. While it was evident that internal consistency (i.e., reliability) was high, having each subset coefficient as well as the total test coefficient being equally large, it was evident that the questionnaire was not measuring the three separate constructs as postulated: understanding, assisting, and copying.That is, the high coefficient for the total test showed a lack of discrimination amongst the items, which necessarily jeopardized validity (Cronbach and Meehl, 1955).

The inter-judge reliability procedure applied to the open-ended questions involved the following steps: (1)the responses on the questionnaire were tabulated; (2) a list of categories was developed from

the responses and codes; (3) the questionnaires were then re-coded by the researcher using the codes attached to each of the categories; and (4) a second person then coded the open-ended questions using the categories developed by the researcher. A reliability check was done for all questions on all of the questionnaires. The reliability of the coding as measured by coder agreement/disagreement with the investigator ranged from 80 to 95 percent.

The public health nurses rated the adequacy of their knowledge of[a] bereavement and the adequacy of their skills relevant to bereavement visiting. In addition, the nurses indicated their level of comfort with regards to affective aspects of bereavement visits. In general, all of the nurses felt they had at least an adequate level of knowledge concerning the items listed in the cognitive domain with two exceptions: 1) cultural differences related to death and dying; and 2) manifestations of grief associated with different causes of death. All of the nurses felt they had at least adequate skill level regarding the items listed in the behavioural domain. There was a wide variety of scores in the affective domain. No single item stood out as making the nurses feel comfortable or uncomfortable when making bereavement visits.

Conclusions Based on the Pilot Study

1) The questionnaire measured what it was suppose to measure with an

a. For the purpose of this study, knowledge of bereavement means knowledge acquired through personal experience with bereavement and/or knowledge acquired through the literature.

adequate degree of consistency and accuracy based on the content and face validity procedures. However, to investigate for the presence of complex constructs, factor analysis would be necessary to use since the alpha coefficients indicated the strong possibility of only one major factor being measured.

2) Overall, the questionnaire appeared to be understandable, relevant and clear from the public health nurses' perspective.

3) The questionnaire design and data analysis elicited emergent findings on the educational needs of the public health nurses with regard to bereavement home visiting.

Based on the findings of the preliminary pilot work, the researcher concluded that it was reasonable to survey the rest of the population of public health nurses with the aim of providing useful information for examining the educational needs of the nurses involved in bereavement home visiting.

Data Collection and Response Rate

One week prior to the distribution of the questionnaire, a letter was sent to potential respondents explaining the intent of the study, ethical considerations, and details concerning receipt of the questionnaire (Appendix V).

The finalized questionnaire (Appendix VII) was sent to each of the 89 potential respondent through the Agency's courier system. None of these respondents participated in the pilot survey. Each questionnaire was coded to identify the respondent as a staff nurse or supervisor from a specific health centre. In addition, the questionnaires were coded with a unique number out of the total "N" expected from any given health centre. This technique was required so that the response rate could be calculated by health centre and as a percentage of the total population. The coding was done by a third party so that respondents could not be identified by the researcher. The respondents were asked to return the questionnaire within one week's time in the self-addressed, stamped envelope enclosed with the questionnaire. Verbal reminders to return the questionnaire were given to the potential respondents by the supervisors one week, and two weeks after receipt of the questionnaire. Only three of the 89 questionnaires were not returned, giving a response rate of 96.6%. All three non-respondents were public health nurses, not supervisors.

Data Analysis Procedure

Factor analysis was used as a descriptive technique: 1) to determine the number and nature of the underlying constructs amongst the larger set of measures; 2) to summarize the data; and 3) to provide a basis for interpretation. Factor analysis can be useful in examining construct validity because questionnaire items measuring the same underlying construct will tend to correlate showing up in the factor solution as loadings

on the same factor. In addition, if the factors postulated a priori as impediments and facilitators of bereavement visiting are confirmed in the results of the factor analysis, then this is a beginning measure of construct validity.

The main purpose of the analysis was to examine, if the specific variable items reported by the nurses converged as postulated, and if the derived factors were interpretable as understanding, assisting, and copying aspects of bereavement visiting as postulated. Both orthogonal and oblique solutions, using varimax rotation were examined. The latter solution was deemed most suitable for this investigation as the constructs affecting bereavement visits were assumed to be correlated and the oblique solution allowed for a clearer interpretation of the data.

Once the most interpretable factorial description of the data was obtained, factor scores were calculated and regression analysis was done to see if relationships existed in any expected manner between the factor scores and various demographic characteristics. The demographic characteristics used in the regression analysis were: age, nursing experience, completion of a values clarification inservice program, experience with bereavement visiting, and experience with personal bereavement. Some frequency tabulations were also derived in order 1) to summarize the raw data; 2) to provide a basis for comparing public health nurses and their supervisors; and 3) to provide summarized data from which

educational programs, program planning, and evaluation could be tailored to various groups of public health nurses. Cross tabulations were used to examine relationships between the frequency counts and demographic variables. Content analysis was used for the open-ended questions to establish the categories of the responses by the respondents. The results and findings of the data analysis are discussed in the next chapter.

CHAPTER IV

PRESENTATION AND ANALYSIS OF DATA

Introduction

The analysis of the data is presented in three sections. First, the data were analyzed using factor analysis to estimate which probable underlying construct(s) best explained the nurses' measured perceptions: the relationships between these factors and substantive demographic variables were the also examined (using multiple regression techniques) in order to confirm the interpretation of the factors. Secondly, frequency counts are used to summarize the raw data both for public health nurses and supervisors. Cross tabulations are used to examine relationships between the raw data and demographic variables. Finally, results on the open-ended questions are reported, based on a content analysis of these findings.

Factor Analysis

Determining the Underlying Constructs

The first factor solution analysis was done on 60 fixed choice items on the questionnaire, and both orthogonal and oblique solutions, using

varimax rotation were derived. Fourteen factors with eigenvalues greater than one were extracted, explaining some 76.6% of the variance of these 60 items. An examination of these oblique and orthogonal factor solutions indicated that at most five significant factors included the majority of the explainable item variance. Accordingly, similar factor analyses were repeated where the number of factors was constrained to be five, then four, then three, and finally two in order. All solutions were examined for the most interpretable solution while still attempting to maintain a reasonable level of proportion of variance that could be explained in the responses to the questionnaire items. Sixteen variables were finally excluded from these analyses because they did not load highly on any factor, or they loaded evenly across all the factors, and thus, did not contribute to an interpretive solution.

In the final analysis, the most satisfactory factor solution was the three factor oblique solution using a varimax rotation on 44 variables (Table I).

Together the three factors accounted for 55.1% of the variance of responses to the 44 item subset: factor one accounted for 42.6% of the variance; factor two 6.9%; and factor three 5.6% of the variance.

TABLE I

FACTOR ANALYSIS -- OBLIQUE SOLUTION VARIMAX ROTATION

Item Number	Item Content	Communalities	Factor I	Factor II	Factor III
21	Knowledge of Psycho-Social Needs of the Bereaved	.425	.573	.065	.087
22	Knowledge of Family Dynamics	.417	.553	-.174	-.030
23	Knowledge of Community Resources	.379	.555	-.078	.036
24	Communication Skills	.580	.791[a]	.046	-.015
25	Teaching Skills	.599	.801	.084	.028
26	Checking-Out Skill	.582	.727	.161	.201
27	Emotional Safety Skill	.597	.541	-.158	.237
28	Responder Skill	.592	.771	-.084	-.041
29	Assessment Skills - Physical Health	.622	.801	-.112	-.223
30	Assessment Skills - Mental Health	.680	.834	-.107	-.194
33	Skill in Dealing with the Emotions of the Bereaved	.653	.499	-.291	.205
34	Skill in Dealing with your own Stress	.491	.639	-.001	.119
35	Skill in Coping with your own feelings about Bereavement	.538	.682	-.084	.010
36	Skill in Expressing Empathy and Caring	.381	.484	-.126	.114
37	Skill in Conducting a Bereavement Visit - Assessment	.691	.383	-.386	.281
38	Skill in Conducting a Bereavement Visit - Planning	.658	.447	-.291	.283
39	Skill in Conducting a Bereavement Visit - Intervention	.694	.445	-.287	.304
40	Skill in Conducting a Bereavement Visit - Evaluation	.689	.386	-.386	.275
41	Skill with Grieving Process Associated with Special Cases	.593	.501	-.298	.132
44	Skill in the Closure of the Initial Visit	.574	.582	.037	.319
45	Skill in Follow-up	.627	.753	.070	.144
31	Assessment Skills - Spiritual Needs	.507	.390	-.495	-.177
32	Assessment Skills - Suicide Risk	.450	.238	-.574	-.189
46	Comfort Level with Visit - Age of Deceased Baby	.620	-.090	-.836	-.020
48	Comfort Level with Visit - Age of Deceased Teenager	.690	.142	-.761	-.033
49	Comfort Level with Visit - Age of Deceased Young Adult	.621	-.053	-.802	-.036
50	Comfort Level with Visit - Age of Deceased Middle-Aged	.604	.219	-.599	.093
51	Comfort Level with Visit - Age of Bereaved - Middle-Aged	.472	.193	-.543	.056
52	Comfort Level with Visit - Age of Bereaved - Young Adult	.584	-.087	-.764	.111
55	Comfort Level - Type of Death - Suicide	.634	-.006	-.731	.163
56	Comfort Level - Type of Death - Accidental	.601	-.083	-.700	.267
57	Comfort Level - Type of Death - SIDS	.546	.121	-.700	-.061
12	Knowledge of the Normal Process - Common Feelings	.553	.173	.075	.680
13	Knowledge of the Normal Process - Common Physical Symptoms	.431	.215	.152	.587
14	Knowledge of the Normal Process - Adjustment Period	.406	.169	.046	.563
42	Skill - Initial Contct	.498	.358	-.036	.452
43	Skill - Entry	.581	.399	-.031	.480
58	Comfort Level with Own Experience with Bereavement	.375	-.105	-.157	.591
59	Comfort Level with Own Experience with Nursing Skill	.426	-.086	-.105	.648
60	Comfort Level with Own Experience with Knowledge of Bereavement	.536	.291	-.095	.504
63	Comfort Level with Own Experience with Clarity of Own Values	.369	.188	-.074	.463

a. loadings of .70 and greater are underlined

Note: The items have been re-ordered from the original for ease of viewing the factors.

In order to convey the essence of the three factors, each is described in turn, along with listings of the items which loaded well on each factor. While the interpretation discussion will focus mainly on those factors that had higher loadings, it is important to note that all items, whether the loading was high or low, contribute to a wider understanding of the actual nature of the factor.

Factor I

The first and strongest factor was comprised of all but four of the skill variables listed in the behavioural domain, as well as three variables from the cognitive domain. The factor was labelled "Perception of Skill". Those items that loaded 0.7 or greater (Table I - Items 24, 25, 26, 28, 29, 30, 45), relate to fundamental skills that are inherent in any visit that a public health nurse makes regardless of the purpose of the visit: these include such skills as communication, teaching, etc. Other variables, including the three from the cognitive domain, which had loadings in the 0.5 to 0.7 range (Items 21, 22, 23, 27, 34, 35, 41, 44) related to skills or knowledge more specific to the bereavement home visit (e.g., knowledge of the psychosocial needs of the bereaved, skill in dealing with emotions of the bereaved).

Factor II

Aspects of bereavement home visiting loading well on Factor II primarily related to behavioural and affective aspects in handling cases

where unexpected death had occurred. The highest loadings (Items 46, 48, 49, 52, 55, 56, 57) were derived from the affective domain, all descriptors of the nature of unexpected death, for example, type of death Sudden Infant Death Syndrome, young age of deceased (baby, teenager), age of bereaved (young adult). Conspicuous by their absence of high loadings were the circumstances of expected death, for example, age of deceased (senior), age of bereaved (senior). Although the loadings were slightly lower, the two variables from the behavioural domain both reflected specific skills related to unexpected death, for example, assessment skills of suicidal risk and spiritual needs. Thus, this factor was labelled "Attitude Towards Unexpected Death".

Factor III

Aspects of bereavement home visiting loading reasonably well on Factor III primarily related to knowledge items about bereavement (Items 12, 13, 14), and skill and affective items fundamental to being prepared to make home visits (Items 42, 43, 58, 60, 61, 62, 63). Accordingly, this factor was labelled "Fundamentals Prerequisite to Bereavement Home Visiting". The knowledge items in this factor are those that Bloom (1964) describes as knowledge of specifics or facts (p. 201-207). The "normal" process of bereavement is well documented in the literature by a variety of authors. The affective and skill items (clarity of one's values, confidence

in nursing skill and experience, etc.) are basic feelings or considerations that contribute to a nurse's feelings of comfort when assessing one's ability to make any type of home visit regardless of its purpose.

Discussion of the Results in Relation to Change and Learning Theory

Change Theory

The derived factor solution provides information regarding factors that impede and facilitate making bereavement home visits. Each factor represents a focus of nursing practice relevant to bereavement visiting in which public health nurses will have a variety of levels of competence and comfort. Depending on their perception of their competence and/or comfort level, each nurse will perceive these foci of nursing practice as facilitative of or impediments to carrying out bereavement home visits. The status of this population regarding the level of competence and comfort with these factors is presented later in this chapter.

Learning Theory

The results of the factor analysis procedure resulted in three distinct factors relevant to bereavement home visiting. Pedagogical science focussed on the three domains of human activity — cognition, behaviour, and affect -- as the basis to modifying growth, development, and learning.

These domains were used as the framework in the development of the questionnaire. However, as highlighted in the literature review, effective learning, in reality, may involve the interplay of all three domains.

Factor I, the strongest factor which accounted for the bulk of the variance, was primarily behaviourally based. The respondents clearly identified the skill component in bereavement home visiting which had little confounding influence from the other two domains of cognition and affect. Many of the behavioural variables listed in the questionnaire reflected general skill that could be applied to any home visit public health nurses might make. It would seem that nurses perceived their skill level as fundamental to their practice and could separate their perceptions of the adequacy of their skill from their feelings about the type of visit that is involved.

However, Factor II and III would support the thesis that all three domains do influence learning. The nurses could not separate how adequate they perceived their skills to be in assessing suicidal risk and spiritual needs from their feelings about unexpected death. In addition, perceptions of adequacy of knowledge of specific facts about bereavement were combined with how the nurses felt about their nursing experience, their clarity of their values, etc., and the influence these variables had on their comfort level when making bereavement visits.

In summary, it was not sufficient to consider only the the nurses' perceptions of the adequacy of their behavioural skill in making effective bereavement visits. There knowledge bases, their feelings and attitudes, and the interaction of these towards the type of bereavement visit and their confidence in their nursing and personal background influenced their perception of the adequacy of their skill and knowledge.

Relationship Between the Factor Solution and Significant Demographic Characteristics of Subjects

Factor scores for each subject were extracted for each of the three factors obtained. A regression analysis subsequently was done on the factor scores utilizing demographic characteristics of the sujects as predictors. The results of the regression analysis procedures used to examine the difference between the demographic variables in relation to the three factors are shown in Table II. These results indicate that none of the demographic variables was statistically significant predictor for any of the three factors at the 0.05 (two-tailed) significance level. The simultaneous regression solution utilizing all of the demographic variables involving stepwise entry of the factor scores generated from Factor I, II, and III accounted for only 9.4%, 12.5%, and 16.8% of the variance respectively. In the event that some of the variables were not distributed in linear fashion, the scatter plots for each variable on each factor were examined for the presence of a non-linear solution. All of the plots appeared to be randomly distributed. Therefore, no non-linear transformations were made for further regression investigations.

Discussion of the Results in Relation to the Literature

The literature is remarkable for its paucity of information regarding relationships between demographic variables and factors that impede or facilitate bereavement home visiting. Further, the few studies done comparing demographic variables and attitudes towards death and dying does not present any clear picture of relationships that could be expected to pertain. That being the case, it is difficult to substantiate or refute the findings of this analysis. These results are similar to those found by other researchers that reported no significant relationships between the demographic variables and attitudes towards death and dying.

Although significant relationships were not necessarily expected for several demographic predictors, given the findings reported in the literature, it seemed reasonable to expect that experience, both nursing experience in general and experience with bereavement home visiting, might have some significant positive influence on the nurses' scores. However, individually, the experience variables (years of nursing experience, years of public health nursing experience, number of bereavement visits made, and years making bereavement visits) were not significant statistically and even in combination, all four variables did not account for a statistically significant amount of the variance. Benner

(1984) suggests experience transforms the nurse so that they "just know" what to do. If the results of this study are valid, another perspective for bereavement visiting must be examined. Considering the uncertain knowledge base of bereavement and the great diversity of circumstances which the nurse may face while making bereavement visits, the experience gained from such visits may not necessarily lead to a sense of mastery and competence.

The preceeding discussion focussed on the factor analyses of data. The regression analysis yielded no significant relationships between the factor scores and the demographic variables, even though experience particularly was considered to be a probable predictor. In view of this, one must consider the following possibilities: 1) the instrument was a poor measurement tool; or 2) the problem was one related to interpretation of the derived factors. To pursue this latter possibility necessitated an examination of the raw data. If expected relationships emerged between the raw data and demographic characteristics of the subjects, then the interpretation of the factors could be more critically examined.

TABLE II

REGRESSION ANALYSIS

Correlations Between Predictor and Factors

PREDICTOR	FACTOR 1			FACTOR 2			FACTOR 3		
	Mult. R	R^2	Sign. Level	Mult. R	R^2	Sign. Level	Mult. R	R^2	Sign. Level
Age	.014	.0002	.90	.169	.029	.123	.123	.015	.26
Nursing Experience	.069	.005	.533	.162	.026	.143	.174	.030	.113
Public Health Nursing Experience	.045	.002	.688	.141	.019	.201	.109	.102	.325
Education	.065	.004	.559	.210	.044	.055	.095	.009	.391
Completion of VAP	.114	.013	.300	.202	.041	.065	.063	.004	.567
Year Completed VAP	.121	.015	.272	.125	.016	.258	.074	.005	.503
Number of Bereavement Visits Made	.123	.015	.265	.107	.011	.332	.092	.008	.405
Years Making Bereavement Visits	.017	.0003	.881	.176	.031	.109	.132	.017	.232
Experienced Personal Bereavement	.037	.0014	.736	.032	.001	.772	.019	.0004	.86

Final Step Statistics —
Stepwise Entry of all Predictors by Factors

Factor	Multiple R	R^2	Significant Level
Factor 1	.308	.095	.749
Factor 2	.363	.125	.514
Factor 3	.410	.168	.514

Public Health Nurse Data Discussion

Frequency tables are presented summarizing the data generated by the public health nurses and supervisors. The data are grouped by domain and listed by questionnaire item (Tables III, IV, V). Those specific items in which less than 75% of the respondents scored themselves as having at best adequate knowledge and skill, or at least comfort level in the affective domain, are highlighted in the tables.

The knowledge items on which less than 75% of the nurses scored themselves as having adequate knowledge are those that are well documented in the literature. The field generally lacks information on literature on the manifestations of grief associated with age, sex, and type of death. The nurses may lack exposure to this information as it is not yet incorporated into nursing curricula nor is it readily available to the practicing nurse.

The behavioural items and the first eight affective items reflect the theme of Factor II in the factor solution. The public health nurses perceive themselves as having inadequate skills and feelings of discomfort when confronted with visits involving unexpected, unnatural, or premature death. The literature supports this finding. Notably, bereavement follow-up visits involving the death of child, death by suicide, or accident are more traumatic for many care givers (Reeves, 1984).

The remaining affective items were typically of an administrative nature and were concerns specific to the population surveyed. They reflect a concern about lack of time to do adequate visits and a concern about how helpful the visit is for the bereaved client. They are best discussed in conjunction with the qualitative categories derived from the open-ended questionnaire items.

Summary — Aggregate Data

The data were aggregated to present a global picture of the percent of inadequate scores that the nurses had by domain (Table VI). The nurses perceive themselves as having the least concerns with their skill level as 71.2% of the respondents scored themselves as having at least adequate skill. The affective domain appears to be the area of greatest concern as only 23.3% of the nurses perceived themselves as being comfortable when carrying out bereavement visits.

TABLE III

COGNITIVE DOMAIN

ITEM	PERCEPTION OF KNOWLEDGE			
	Public Health Nurses		Supervisors	
	Percent Adequate	Percent Inadequate	Percent Adequate	Percent Inadequate
Normal Process of Bereavement:				
. Common Feelings	97.2	2.8	100	--
. Normal Physical Changes	97.2	2.8	100	--
. Adjustment Period	93.0	7.0	90.0	9.1
Risk Factors	74.6[a]	25.4	72.7	27.3
Sign and Symptoms of Abnormal Grief	70.0	30.0	54.4	45.5
Cultural Differences	28.6	71.5	72.7	27.3
Manifestations of Grief by Cause of Death	53.5	46.4	100	--
Manifestations of Grief by Sex	59.2	40.8	90.9	9.1
Manifestations of Grief by Age of Bereaved	60.6	39.4	100	--
Psycho-social Needs of Bereaved	97.2	2.8	90.9	9.1
Family Dynamics	79.7	20.3	100	--
Community Resources	81.7	18.3	90.9	9.1

a. Items for which less than 75 percent of the respondents scored themselves as having at best adequate knowledge are underlined.

TABLE IV

BEHAVIOURAL DOMAIN

ITEM	PERCEPTION OF SKILL			
	Public Health Nurses		Supervisors	
	Percent Adeq.	Percent Inadeq.	Percent Adeq.	Percent Inadeq.
Communication Skills	98.6	1.4	100	--
Teaching Skills	94.4	5.6	100	--
Checking-Out Skill	88.6	11.4	81.8	18.2
Emotional Safety Skill	87.3	12.7	81.8	18.2
Responder Skill	85.7	14.3	90.9	9.1
Assessment Skills: Physical Health	95.8	4.2	100	--
Mental Health	80.0	20.0	100	--
Spiritual Health	62.0[a]	38.0	54.5	45.5
Suicidal Risk	47.1	52.9	27.3	72.7
Skill in Dealing with the Emotions of the Bereaved	75.7	24.3	40.0	60.0
Skill in Dealing with Own Stress	81.7	18.3	66.7	33.3
Skill in Coping with Feelings about Bereavement	95.8	4.2	50.0	50.0
Skill in Expressing Empathy and Caring	100	--	90.9	9.1
Skill in Conducting a Bereavement Visit:				
. Assessment	87.0	13.0	100	--
. Planning	80.0	20.0	90.9	9.1
. Intervention	57.7	24.3	90.9	9.1
. Evaluation	75.7	24.3	72.7	27.3
Skill in Grieving Process Associated with Special Cases	50.0	50.0	50.0	50.0
Skill - Initial Contact	85.5	14.5	80.0	20.0
Skill - Entry	89.9	10.1	72.7	27.3
Skill - Closure of First Visit	84.1	15.9	72.7	27.3
Skill - Follow-up	80.0	20.0	60.0	40.0

a. Items for which less than 75 percent of the respondents scored themselves at best adequate skill are underlined.

TABLE V

AFFECTIVE DOMAIN

ITEM		PERCEPTION OF COMFORT LEVEL			
		Public Health Nurses		Supervisors	
		Percent Comf.	Percent Uncomf.	Percent Comf.	Percent Uncomf.
Age of Deceased:	Baby	52.9[a]	47.1	36.4	64.6
	Senior	98.6	1.4	81.8	18.2
	Teenager	31.0	69.0	27.3	72.7
	Young Adult	50.7	49.3	27.3	72.7
	Middle-Aged Adult	63.4	36.6	36.4	63.6
Age of Bereaved:	Middle-Aged Adult	81.7	18.3	72.7	27.3
	Young Adult	62.9	37.1	72.7	27.3
	Senior	94.4	5.6	72.7	27.3
Type of Death:	Expected	100	--	90.9	9.1
	Suicide	29.6	69.4	--	100
	Accidental	59.2	40.8	9.1	90.9
	SIDS	53.5	46.5	27.3	72.7
Own Experience with Bereavement		88.6	11.4	90.0	10.0
Nursing Skill		95.7	4.3	100	--
Own Nursing Experience		91.4	8.6	90.9	9.1
Knowledge of Bereavement		87.1	12.9	81.8	18.2
Showing own Emotions		87.3	12.7	10.0	90.0
Clarity of own Values		90.1	9.9	90.9	9.1
Potential to be Harmful		54.4	45.6	30.0	70.0
Potential to Invade Privacy		51.5	48.5	30.0	70.0
Belief that Visits Benefit Client		81.2	18.8	100	--
Lack of Information on Death Notices		23.9	46.1	72.7	27.3
Lack of Resources to which to refer Clients		35.2	64.8	63.6	36.4
Time: Limited Amount to do Bereavement Visits		31.0	69.0	72.7	27.3
Lack of Time to Visit all Clients		75.7	24.3	18.2	87.8
Lack of Time to do Followup		19.7	80.3	9.1	90.0

a. Items for which less than 75 percent of the respondents scored themselves as having at best comfort level are underlined.

TABLE VI

AGGREGATE DATA
Percent of Inadequate Scores by Domain for Public Health Nurses (percent)

Percent of Inadequate Scores	Cognitive Domain		Behavioural Domain		Affective Domain	
	Percent of PHNs	Cum. Per.	Percent of PHNs	Cum. Per.	Percent of PHNs	Cum. Per.
No Inad. Scores	20.5	20.5	21.9	21.9	1.4	1.4
1-25%	35.6	56.2	49.3	71.2	21.9	23.3
25-50%	31.5	87.7	20.5	91.8	43.4	76.7
50-75%	12.3	100	5.5	97.3	23.3	100
75%	—	—	2.8	100	—	—

Relationships Between the Raw Data and Demographic Variables

A breakdown of the demographic information is presented in Table VII. There is a reasonable representation of the respondents in all categories for each variable with the exception of two variables: education and experience, or lack thereof, in making bereavement visits.

Tables VIII through XIII show the results of cross tabulations between the raw scores and demographic variables on those analyses that were statistically significant for an alpha level of 0.05. Two demographic variables, education and experience in making no bereavement visits, are excluded from the following discussion. In the case of these two variables, the vast majority of the respondents were represented in one category only, resulting in very small numbers in the other categories. This makes the interpretation of the data regarding differences between categories impossible.

The following discussion emphasizes general findings gleaned from the analysis. Some of the cross tabulations involved small numbers of respondents in a specific category which means caution must be exercised when interpreting the findings. The findings are discussed under four main headings: experience, completion of an in-service training program, experience with personal bereavement, and age.

TABLE VII

DEMOGRAPHICS OF THE RESPONDENTS

Variable		Frequency	Percent	Variable		Frequency	Percent
Age in Years	Under 25	6	8.5	Nurse has made at least one Bereavement Visit	Yes	70	98.6
	25-34	29	40.8		No	1	1.4
	35-44	23	32.4				
	45-54	8	11.3				
	55-64	5	7.0				
Nursing Experience in Years	0-2	6	8.5	Number of Bereave-ment visits in last six months	Never Made	1	1.4
	3-5	7	9.9		Over 8	17	23.9
	6-10	23	32.4		5-8	15	21.1
	11-15	13	18.3		1-4	33	46.5
	16+	22	31.0		none	5	7.0
Public Health Nursing in Years	0-2	19	26.8	Exper'd Personal Bereave-ment	Yes wthn 1 yr	7	9.9
	3-5	15	21.1		No	16	22.5
	6-10	19	26.8		Yes, 1-2 yrs	8	11.3
	11-15	8	11.3		Yes, more than 2 yrs	40	56.3
	16+	10	14.1				
Education	Diploma	8	11.3	Years Making Bereave-ment Visits	1 or less	20	28.2
	Baccalaureate	62	87.3		2	8	11.3
	Masters	1	1.4		3	9	12.7
					4	9	12.7
					5	10	14.1
					6	5	7.0
					7	1	1.4
					8+	9	12.7
Values Attitudes and Practice Completed	No	22	31.4				
	Yes-1984+	18	25.7				
	Yes-less 1984	30	42.9				

Experience — Tables VIII, IX, and X

This section includes nursing experience in years, both general nursing and public health nursing experience (Table VIII), the number of bereavement visits made (Table IX), and the number of years a nurse has been making bereavement visits (Table X). There appear to be some general relationships resulting from increased experience:

1) As experience increases, so does the adequacy of skill level as perceived by the nurse, in conducting a bereavement visit; This relationship holds for all four components; assessment, planning, intervention, and evaluation.

2) As experience increases, so does the adequacy of skill level as perceived by the nurse, in carrying out the components of a bereavement visit. This includes initial contact, entry, closure, and follow-up.

3) As experience increases, so do feelings of comfort as perceived by the nurse in relation to making "difficult" bereavement visits, for example, visits where the deceased is a baby or teenager.

4) As experience increases, so do feelings of comfort as perceived by the nurse, in relation to showing her own emotions and coping with the emotions of the bereaved.

TABLE VIII

CROSS TABULATIONS
NURSING EXPERIENCE
BY VARIABLES AFFECTING BEREAVEMENT VISITNG

Variable	Years of Nursing Exp.	Perception of Adequacy (Percent)			
		V. Adeq	Adeq	Inadeq	V. Inadeq
Skill in making Initial Contact of the Bereaved[a]	0-2		100		
	3-5	14.3	57.1	28.6	
	6-10	13.6	68.2	18.2	
	11-15	46.2	30.8	23.1	
	16+	52.4	42.9	4.8	
Skill in making Entry into the Bereaved's Home	0-2		100		
	3-5	14.3	71.4	14.3	
	6-10	18.2	63.6	18.2	
	11-15	46.2	38.5	15.4	
	16+	52.4	47.6		
		Perception of Comfort (Percent)			
		V. Comf.	Comf.	Uncomf.	V. Uncomf.
Comfort Level Associated with their Knowledge of Bereavement	0-2		100		
	3-5	14.3	71.4	14.3	
	6-10	4.5	77.3	18.2	
	11-15	46.2	23.1	30.8	
	16+	40.9	59.1		
Comfort Level Associated with Showing their own Emotions	0-2		100		
	3-5	28.6	71.4		
	6-10	8.7	78.3	13.0	
	11-15	23.1	38.5	38.5	
	16+	18.2	77.3	4.5	
Comfort Level Associated with Clarity of their Values	0-2	45.0	55.0		
	3-5	6.7	66.7	6.7	
	6-10	33.3	38.1	28.6	
	11-15	41.7	50.0		8.3
	16+	42.9	57.1		

a. All variables listed are statistically significant for an alpha level of 0.05.

TABLE IX

CROSS TABULATIONS
NUMBER OF BEREAVEMENT VISITS
BY VARIABLES AFFECTING BEREAVEMENT VISITING

Variable	Number of Visits Made	Perception of Adequacy			
		V. Adeq	Adeq	Inadeq	V. Inadeq
Skill in making Entry into the Bereaved's Home[a]	No Visits		100		
	Over 8	64.7	35.3		
	5-8	35.7	64.3		
	1-4	18.8	62.5		
	0		20.0		
Skill in Closure Bereavement Visit	No Visits				
	Over 8	47.1	52.9		
	5-8	21.4	64.3	14.3	
	1-4	12.1	66.7	21.3	
	0		60.0	40.0	
Skill in Follow-up	No Visits		100		
	Over 8	4.2	52.9	5.9	
	5-8	28.6	50.0	21.4	
	1-4	15.2	66.7	18.2	
	0		40.0	60.0	
		Perception of Adequacy			
		V. Adeq	Adeq	Inadeq	V. Inadeq
Perception of Comfort in Visiting Seniors who are Bereaved	No Visits		100		
	Over 8	58.8	41.2		
	5-8	40.0	60.0		
	1-4	30.3	69.7		
	0	40.0	40.0	20.0	

a. All variables listed are statistically significant for an alpha level of 0.05.

TABLE X

CROSS TABULATIONS
YEARS DOING BEREAVEMENT VISITS
BY VARIABLES AFFECTING BEREAVEMENT VISITING

Variable	Years Doing Bereav. Visits	Perception of Adequacy			
		V. Adeq	Adeq	Inadeq	V. Inadeq
Skill in Dealing with Emotions of the Bereaved[a]	2 or less	7.1	67.9	25.0	
	3-5	14.3	50.0	35.7	
	6-8+	37.5	62.5		
Skill in Conducting a Visit - Assessment	2 or less	7.1	85.7	7.2	
	3-5	22.2	31.9	29.5	
	6-8+	31.3	68.8		
Skill in Conducting a Visit - Planning	2 or less	10.7	75.0	14.3	
	3-5	10.7	57.1	35.7	
	6-8+	31.2	68.8		
Skill in Conducting a Visit - Intervention	2 or less	3.6	71.4	25.0	
	3-5	10.7	53.6	35.7	
	6-8+	25.0	75.0		
Skill in Conducting a Visit - Evaluation	2 or less	3.6	71.4	25.0	
	3-5	14.3	50.0	35.7	
	6-8+	25.0	75.0		
Skill in Initial Contact of the Bereaved	2 or less	17.9	64.3	17.8	
	3-5	32.1	50.0	17.9	
	6-8+	60.0	40.0		
Skill in Entry into the Bereaved's Home	2 or less	21.4	67.9	10.7	
	3-5	32.1	53.6	14.3	
	6-8+	60.0	40.0		
Skill in Closure of Initial Visit		14.8	66.7	18.5	
		10.7	67.9	21.4	
		56.3	43.7		
		Perception of Adequacy			
		V. Comf.	Comf.	Uncomf.	V. Uncomf.
Comfort Level with Visits - Age of Deceased - Baby	2 or less	7.2	32.1	35.7	25.0
	3-5	10.7	32.1	42.9	14.3
	6-8+	31.3	56.3	6.3	6.3
Comfort level with Visits - Age of Decreased - Teenager	2 or less		21.4	67.9	10.7
	3-5	3.4	13.8	58.6	24.1
	6-8+	12.5	56.3	25.0	6.2
Comfort level with Age of Deceased - Middle-Aged	2 or less	3.6	60.7	35.7	
	3-5	10.3	34.5	55.2	13.8
	6-8+	31.3	62.5	6.2	
Comfort with Showing Own Emotions	2 or less	3.6	82.1	14.3	
	3-5	13.8	69.0	17.2	
	6-8+	37.5	62.5		
Comfort with Belief that Visits Benefit the Clients	2 or less	39.3	39.3	21.4	
	3-5	21.4	53.6	17.9	7.1
	6-8+	53.5	40.0	6.7	

a. All variables listed are statistically significant for an alpha level of 0.05.

The findings support Benners' (1984) conclusions that experience is important in leading a nurse towards a sense of mastery and competence. As the respondents' experience increased, so did the adequacy of skill level as perceived by the nurses in relation to the bereavement visiting process and their perception of comfort in making visits in general and specifically making the more "difficult" bereavement visits. This may be indicative of nurses gaining competence and feeling more capable in making bereavement visits.

Completion of "Values, Attitudes, and Practice" (VAP) — Table XI

Respondents who had completed VAP inservice program reported feeling more comfortable when making visits where the deceased was a senior, a teenager, a young adult, and when the type of death was SIDS, as compared with respondents who had not completed VAP. In addition, these same respondents reported less adequate skill level in making entry into the bereaved's home and skill in closure of the initial bereavement visit.

Authors suggest that clarifying one's own values and philosophy about life and death is important when making bereavement visits. The findings here suggest that VAP program may be helpful in making the nurses feel more comfortable when making the visits, and notably, more comfortable when the circumstances of the death may be perceived as traumatic.

TABLE XI

CROSS TABULATIONS -- COMPLETED "VALUES, ATTITUDES, AND PRACTICE"

Variable	Completed VAP and Year	Perception of Adequacy			
		V. Adeq	Adeq	Inadeq	V. Inadeq
Skill in making Entry into the Bereaved's Home[a]	not completed	22.7	77.3		
	completed 1984+	33.3	38.9	27.8	
	before 1984	39.3	53.6	7.1	
Skill in Closure of First Visit	not completed	14.3		9.5	
	1984+	33.3	33.3	33.3	
	before 1984	20.7	69.0	10.3	
		Perception of Comfort			
		V. Comf.	Comf.	Uncomf.	V. Uncomf.
Comfort Level Assoc'd with Visits - Age of Decreased - Teenager	not completed		9.1	77.3	13.6
	1984+	5.6	44.4	50.0	
	before 1984	6.7	26.7	40.0	26.7
Comfort Level Assoc'd with Visits - Age of Deceased - Young Adult	not completed		27.3	68.2	4.5
	1984+	11.1	50.0	33.3	5.6
	before 1984	6.7	53.3	20.0	20.0
Comfort Level Assoc'd with Visits - Age of Bereaved - Senior	not completed	18.2	68.2	13.6	
	1984+	27.8	66.7	5.6	
	before 1984	60.0	40.0		
Comfort Level Assoc'd with Type of Death - SIDS	not completed	4.5	31.8	50.0	13.6
	1984+	11.1	61.1	5.6	22.2
	before 1984	16.7	36.7	40.0	6.7
Comfort Level Assoc'd with Belief that Visits Help	completed	27.7	44.7	23.4	4.3
	not completed	50.0	50.0		

a. All variables listed are statistically significant for an alpha level of 0.05.

However, regarding the nurses' perception of skill in entry and closure of a bereavement visit, VAP inservice program does not appear to be beneficial. On the other hand, completion of a value clarification in-service program may result in the nurses being more acutely aware of their potential influence on clients, both positive and negative, resulting in some feelings of inadequacy as noted here, whereas the nurses not exposed to that type of program may underestimate the complexity and acuity of clients' feelings.

Experience with Personal Bereavement — Table XII

Nurses who reported having personal experience with bereavement tend to perceive their knowledge of the normal adjustment period of bereavement at a higher level of adequacy than do those nurses with no experience with personal bereavement. In addition, those nurses who had personal experience with bereavement reported a greater degree of feelings of comfort in making bereavement visits.

Rogers and Vachon (1975) consider personal experience with bereavement as helpful when making bereavement visits. These findings concur with that point in a limited sense. The respondents report a greater degree of feelings of comfort when making the visits which is not necessarily indicative of increased skills or other nursing actions as Rogers and Vachon suggest.

TABLE XII

CROSS TABULATIONS
EXPERIENCED BEREAVEMENT
BY VARIABLES AFFECTING BEREAVEMENT VISITING

Variable	Personal Bereav. Stats	Perception of Adequacy			
		V. Adeq	Adeq	Inadeq	V. Inadeq
Knowledge of Adjustment Period of Bereavement[a]	Yes within 1 yr	57.1	42.9		
	No	23.5	47.1	29.4	
	Yes within 1-2 yrs	25.0	75.0		
	yes more than 2 yrs	24.4	75.6		
		Perception of Comfort			
		V. Comf.	Comf.	Uncomf.	V. Uncomf.
Comfort Level Associated with Visiting Bereaved	Yes within 1 yr	57.1	42.9		
	No	29.4	58.8	11.8	
	Yes within 1-2 yrs	12.5	62.5	25.0	
	Yes mre than 2 yrs	43.9	56.1		
Comfort Level Associated with Own Experience with Bereavement	Yes within 1 yr	57.1	28.6		
	No	11.8	70.6	17.6	
	Yes within 1-2 yrs	62.5	25.0	12.5	
	Yes more than 2 yrs	25.0	67.5	7.5	

a. All variables listed are statistically significant for an alpha level of 0.05.

Age — Table XIII

As age increases, the respondents report a higher level of adequacy of skill in the initial contact with the bereaved; also knowledge of bereavement was positively associated with a greater degree of feelings of comfort when making bereavement visits. Such findings are not reported in the literature and should be viewed as isolated and descriptive pieces of information. Age, in general terms, did not present any significant general relationships

Relationships Between Public Health Nurses and Supervisors

The summary data from the supervisors' responses involve 11 respondents and, as such, is very limited in its interpretation. However, because these responses reflect the perceptions of all of the nurse managers responsible for this unique bereavement program, they provide relevant descriptive information in terms of offering some beginning clues about possible interventions in the behavioural and affective areas of bereavement visiting.

Cognitive

There was considerable lack of agreement between the public health nurses and supervisors in the cognitive domain. However, this is probably the most difficult area for the supervisor to assess unless she had had access to the results of a "knowledge of bereavement test" for her staff. The discrepancies are not viewed by the researcher as meaningful.

Behavioural

The public health nurses and supervisors are in total agreement on those behavioural items listed by the nurses. The supervisors note two other general areas of concern: 1) the staff nurses' skills in dealing with the emotions of the bereaved and dealing with their own emotions during bereavement visits; and 2) the staff nurses' skills in carrying out the components of a bereavement visit. It may be that these two additional areas arise because the supervisor is able to make these observations from a distance and with an objectivity which ensures a more accurate evaluation than could be achieved by the public health nurse making the visit.

TABLE XIII

CROSS TABULATIONS
AGE
BY VARIABLES AFFECTING BEREAVEMENT VISITING

Variable	Age in Years	Perception of Adequacy			
		V. Adeq	Adeq	Inadeq	V. Inadeq
Skill in making Initial Contact with the Bereaved[a]	Under 25		100		
	25-34	13.3	63.3	23.3	
	35-44	30.8	61.5	7.7	
	45-54	50.0	20.0	30.0	
	55-64	57.1	42.9		
		Perception of Comfort			
		V. Comf.	Comf.	Uncomf.	V. Uncomf.
Comfort Level Associated with Knowledge of Bereavement	Under 25		100		
	25-34	13.3	66.7	20.0	
	35-44	33.3	51.9	14.8	
	45-54	72.7	18.2	9.1	
	55-64	42.9	57.1		

a. All variables listed are significant for an alpha level of 0.05.

Affective

There is general consensus concerning affective items between the supervisors and the public health nurses with one notable exception. The supervisors reported that a majority of the staff nurses would feel uncomfortable about the possibility of showing their own emotions when making a bereavement visit. The staff nurses did not have this concern. Again, as stated in the discussion of the behavioural factors, the supervisors assessed this factor (showing one's emotions) from a distance and with an objectivity that could not be achieved by the public health nurses making the visits. The general consensus of responses in the affective area may indicate that the supervisors have a clear understanding of those areas of bereavement visits that the nurses perceive to be of greatest concern. Specifically, these areas are 1) discomfort with visits involving unexpected death, and 2) discomfort with administrative limitations, e.g., perceived lack of time to do the visits.

Qualitative Analysis

The three questions (Numbers 15b, 16, and 17) on the questionnaire which solicited a written response and were analyzed qualitatively will be discussed by question. Initially, the discussion will focus on the staff

nurses' responses to each question followed by a comparison of the supervisors and staff nurses responses.

Priority for Bereavement Visiting

Table XIV shows that 76% of the public health nurses think that the bereavement home visiting program should be given at least a medium priority, but only 36% of the public health nurses think they are able to give the program that priority. This presents an obvious discrepancy. The most frequently cited reason for the discrepancy in priority was time constraints (Table XV). Within the time constraint category, the public health nurses most frequently reported that the demands from other programs made it difficult to allot adequate time for bereavement visits. Notably, most of the reasons cited for assignment of priority involved administrative constraints rather than a lack of comfort in making the visits, or a perceived need for further training or knowledge.

TABLE XIV

PRIORITY OF BEREAVEMENT VISITS: DESIRED AND EXTANT

Desired: Priority EBH Should Give to Bereavement Visits

Rating	Public Health Nurses		Supervisors	
	Percent	Cum. Percent	Percent	Cum. Percent
High	22.5	22.5	9.1	9.1
Medium	53.5	76.1	63.6	72.7
Low	21.1	97.2	27.3	100
No Priority	2.8	100	--	--

Extant: Priority You Can Give to Bereavement Visits

Rating	Public Health Nurses		Supervisors	
	Percent	Cum. Percent	Percent	Cum. Percent
High	2.9	2.9	--	--
Medium	33.3	36.2	50.0	50.0
Low	62.3	98.6	50.0	100
No Priority	1.4	100	--	--

TABLE XV

QUESTION 15b
EXPLANATION OF PRIORITY ASSIGNED TO BEREAVEMENT HOME VISITS

	CATEGORY	FREQUENCY	
		Public Health Nurse N = 98	Supervisor N = 17
I	Time constraints	6	
	- Lack of time to do follow-up	4	2
	- Other program demands	34	4
	- Visits very lengthy -- difficult to find block of time	7	2
	- Not emergency visits so lower priority	1	
	- Too many bereavement visits to do them all	1	
	- Number of visits manageable	3	1
	TOTAL:	56	9
II	Priority established by administration		
	- Other programs come first (babes/at risk)	6	1
	- High seniors population so allotted a high priority	3	1
	TOTAL:	9	2
III	Priority depends on risk and age group	9	
IV	Difficulty in contacting survivors -- not available during day	5	
V	Lack of nursing resources	4	3
VI	Lack of comfort with visits	4	
VII	Need inservice/training to do an adequate job	2	1
VIII	Lack of resources to which to refer clients	2	1
IX	Lack of information on death notices	2	
X	Most clients coping -- don't appear to need visits	2	
XI	Early intervention and support are very important	2	
XII	Unclear program expectations	1	

Are Bereavement Visits Beneficial to the Clients

Table XVI shows that 77% of the public health nurses think the clients benefit from the bereavement visit. Missing data is included as a category in this table as it represents an undecided respondent (in all but two of the cases) as opposed to a respondent who simply did not complete this item on the questionnaire. Table XVI lists the categories and frequency of yes, no, and undecided responses to the question. Categories 1 through 6 are well supported in the literature as commonly felt needs of the bereaved and/or actions helpful to the bereaved client (Whelan, 1985; Alexander and Kiely, 1986). There is agreement then between what these public health nurses perceive as being helpful to bereaved clients and what some bereaved people have reported as helpful intervention as gleaned from the literature.

Comments and Suggestions

Table XVII shows the categories derived from the last question which asked for further comments and suggestions. In addition, the table displays the frequency of response within each category. The public health nurses' responses fell into three main themes: 1) the bereavement visiting program is a valuable service, but 2) there are general resource constraints (time and staff) which make it difficult to do an adequate job. In addition, the public health nurses offer a variety of administrative comments and suggestions about the program, for example, priority guidelines for visiting.

TABLE XVI

CLIENTS BENEFIT FROM BEREAVEMENT VISITS

	Public Health Nurses	Supervisors
Yes	77.5	100
No	9.9	--
Missing Data/ Undecided	12.7	--

TABLE XVII

QUESTION 16
EXPLANATION OF WHY NURSES BELIEVE CLIENTS BENEFIT FROM BEREAVEMENT VISITS

	CATEGORY	FREQUENCY	
		Public Health Nurse N = 114	Supervisor N = 22
I	Public Health Nurse in an objective, neutral listener	25	4
II	Public Health Nurse provides information on community resources	10	6
III	Client feels someone cares	10	1
IV	Client knows where to seek help if they need a contact	10	--
V	Public Health Nurse provides support	9	5
VI	Public Health Nurses' assessment important re: referral:	9	4
VII	Clients are receptive to the visit -- welcome the nurse	6	1
VIII	Public Health Nurse reassures the client re: normalcy of their bereavement	6	--
IX	Client tells Public Health Nurse they have benefitted	3	1
	TOTAL:	88	22
	Undecided or No Answer		
I	Most clients already have adequate support	11	
II	Unable to assess if visit is beneficial	5	
III	Benefit depends on age and cause of death	3	
IV	"One shot" visit probably inadequate	3	
V	Clients resistive to Public Health Nurse entry or decline visit	3	
VI	Other agencies involved -- don't need visits	1	
	TOTAL:	26	

TABLE VXIII

QUESTION 17 — FURTHER COMMENTS AND SUGGESTIONS

	CATEGORY	FREQUENCY	
		Public Health Nurse N = 55	Supervisor N = 9
I	Bereavement home visiting is a valuable service	13	3
II	Resource constraints problematic -- time, staff, budget	13	1
	TOTAL:	26	4
III	Administrative Suggestions		
	- Anniversary follow-up not useful	1	
	- Conflicting guidelines re: entry -- should be Public Health Nurses' discrestion	1	
	- Priority of visiting guidelines		
	i) SIDS & children	2	
	ii) men under 65 years		
	middle-aged women		
	seniors -- lower prioirty	3	
	- Lack of information on notice -- very frustrating	4	2
	- Leaving form letter not useful	1	
	- People not home/difficult to locate	3	
	- Public unaware of service	2	
IV	Inservice/Education needed in order to do effective job	6	3
	- Should be a speciality	2	
V	Question program's effectiveness	4	

Relationship Between Responses Made By Supervisors and Public Health Nurses

The supervisors are in agreement with the staff nurses regarding the priority that should be given to the bereavement program, i.e., medium/high priority (Table XIV). However, in practice, 50% of the supervisors were able to assign a medium/high priority to this program as compared to the public health nurses where only 36% of this group could assign a medium/high priority. The supervisors cite administrative constraints as the reasons for the discrepancy in the program priority. These reasons reflect their position as a manager of a program as opposed to the personnel who carry out the program. Notably, both supervisors and public health nurses have the greatest concern with time constraints.

The supervisors unanimously agree that the program is beneficial to clients. The supervisors express the positive influences which the public health nurse may have on these clients and are devoid of the ambivalence expressed by some of the staff nurses when they answered this question. The lack of ambivalence towards the bereavement program may reflect an attitude eminating from the nurse managers role and responsibility to carry out effective programs. On the other hand, it may simply reflect a lack of experience in actually doing bereavement visits.

CONCLUSIONS AND RECOMMENDATIONS

In this chapter, the conclusions and recommendations from the findings are delineated. In addition, some implications for further research are explored.

Conclusions

The findings from this research provide information on public health nurses' perceptions of factors that facilitate or impede carrying out bereavement home visits from three types of data analysis: 1) factor analysis, 2) the frequencies generated from the raw data, and 3) qualitative analysis.

The three factors which emerged from the factor analysis solution capture the impediments and facilitators in making bereavement home visits in terms of the foci of nursing practice in bereavement home visiting.

Of these three factors, the key finding in this study was factor II, Attitudes Towards Unexpected Death. The respondents clearly separated the circumstances of unexpected or premature death as a source of

potential concern or discomfort when making bereavement visits. Many authorities on bereavement visiting identify unexpected death as the greatest source of concern and trauma for nurses who are caring for the families in which such an event happens (Reeves, 1984; Brown, 1982; Davies, 1986). Thus, this factor was deemed the greatest impediment in effective bereavement visiting. Both factor I, Perception of Skill, and factor III, Prerequisites to Bereavement Home Visiting underline the importance of nursing fundamentals (skill and knowledge) as well as the importance of confidence in one's skill, knowledge, and experience in carrying out effective bereavement visits. However, these two factors reflect components of any type of home visit, not only bereavement visits. From this perspective factor II, Attitudes Towards Unexpected Death should be assigned the greatest importance.

The raw data provide detailed information regarding the adequacy of knowledge and skills items and comfort level in the affective items. In general, the majority of public health nurses in this population perceive themselves as having at least adequate skill to carry out an effective bereavement visit. Both the cognitive and affective domains show a higher percentage of the nurses as perceiving they have inadequate knowledge of bereavement and feelings of discomfort when making the visits. The nurses can confidently draw upon their nursing skills to help them carry out effective visits. However, the findings indicate that the nurses perceive themselves as needing knowledge of bereavement in specific areas and

training in specific skills. In addition, consideration should be given to the feelings and attitudes the nurses have about bereavement visiting, particularly feelings about visits involving unexpected or premature death.

The findings from the qualititative analysis show that 75% of the nurses believe that the clients benefit from the bereavement visits and that the visiting program should be given at least a medium priority. The raw data indicate that nurses are aware of those behaviours and actions that are most helpful to bereaved clients and that they, as public health nurses, are in a position to provide that care. The belief that these visits are helpful to the client and that public health nurses are able to deliver that care, provides a strong incentive for the nurse to carry out an effective visit. However, there is a large discrepancy between the priority that should be given to the program and what priority the nurses are actually "able to" give to bereavement visiting. The overwhelming factor that contributes to this discrepancy is the nurses' perception of inadequate time to carry out effective visits. For the most part, the nurses view the management of this time to be out of their control. The time constraints arise because of the demands of other programs and the lack of resources, particularly personnel, to adequately carry out the bereavement program. The nurses' perceptions of the constraints of time may act as a significant barrier in making effective bereavement visits.

Nursing supervisors are viewed by the researcher as influential in supporting their staff in accomplishing program objectives. The findings of this research suggest that the supervisors are well aware of their nurses' perceptions of their knowledge, skills, and attitudes concerning bereavement home visiting. They all believe the clients benefit from the bereavement program and view the nursing staff as key personnel involved in the grieving process. Although it is presumptive to assume that these findings of supervisors' perceptions would facilitate the nurses in making bereavement visits, it is reasonable to conclude that the nursing supervisors' attitudes towards their staffs' abilities and towards the bereavement program would not impede the nurses carrying out effective visits.

The regression analysis yielded no significant relationships between the demographic characteristics of the population and the factor scores. The researcher turned to the raw data in order to further scrutinize the interpretation of the factors affecting bereavement visiting. The demographic characteristics of the population that influenced the perceptions of the nurses were experience, completion of the "Values, Attitudes, and Practice" inservice program and personal experience with bereavement. Of these factors, experience appears to play the most influential role. It appears that the nurses perceived themselves as having somewhat more adequate skill and knowledge and being more comfortable

when making bereavement visits by virtue of just doing more visits, regardless of other influences such as in-service training. Each time a nurse carried out a bereavement visit, she may gain confidence and be able to assess how effective her present skill and knowledge level is in facilitating the grief process for her clients. However, the relationships found significant for an alpha level of 0.05 were restricted to specific skills, i.e., skill in carrying out the components of a visit, and specific areas of affect, i.e., comfort level associated with the age of the deceased being a baby. This provides some additional information relevant to the interpretation of the factors derived from the factor solution. The "Perception of Skill" factor may have subcategories of skills within the main factor. Postulated skill areas could include: 1) skills common to all visits not just bereavement visits, i.e., communication skills; 2) skills addressing the structure and process of the visit rather than the content, i.e., contact, entry and follow-up; and 3) skills that have a component of affect, e.g., skill in dealing with the emotions of the bereaved. The "Attitude Towards Unexpected Death" factor may also have subcategories within this factor. It may be necessary to separate visits where the age of the deceased is more narrowly defined rather than including a wide range of age categories from a young child to a middle-aged adult. Experience could have a different influence on any one or all of these factor subcategories, thus, showing no significant influence when they are combined as a grouping.

Lack of specific and quantifiable measures of the demographic characteristics of the population could have contributed to the lack of

significant relationships between the factor scores and these characteristics. For example, clarity of values and attitudes about death and dying were viewed as important predictors of behaviour. The completion of a values clarification inservice program (VAP) attempted to tap this demographic characteristic, but does not constitute concrete evidence of the actual clarity of the public health nurses' values and attitudes towards death and dying. Personal experience with bereavement was also viewed as an important predictor. However, it may be important to have a specific measure of how well they coped with their own bereavement as a predictor of the public health nurses' behaviour.

Although findings related to the specific significant influence of the "Values, Attitudes, and Practice" inservice program on nurses' perceptions of bereavement visits are limited, the value of such a program should not be underestimated. Findings in the literature emphasize the importance of confronting one's feelings and attitudes towards death and dying in order to develop the ability to carry out effective visits. Given that the findings suggest that the nurses have the greatest needs in the affective area of bereavement, and that the nurses have concerns with bereavement visits involving unexpected death, time and energy spent in value clarification, and confrontation of their own feelings and attitudes about death and dying would seem worthwhile.

Finally, in examining the perceived needs of this population of nurses in terms of factors which facilitate their making effective bereavement

visits, the educational approach should be given careful consideration. The nurses identified specific instances in which they felt they had an inadequate level of skill or knowledge. Information and/or training could be offered to increase the knowledge and skill level. However, the findings suggest that skill and knowledge are not sufficient to adequately prepare the nurses for making effective bereavement visits, especially those involving unexpected death. Attitudes and feelings about bereavement confounded the nurses' perceptions of the adequacy of their skill and knowledge. To the extent that the public health nurses and supervisors in this study are representative, nursing administrators and educators should, at minimum, endeavor to find ways and means of helping public health nurses: (1) to recognize unexpected death as an impediment in bereavement home visiting; (2) to understand the complexities of this type of visit, and; (3) to develop strategies to better cope with bereavement involving unexpected death.

Some Implications for Further Research

As a result of these findings, it is suggested that the study be replicated using public health nurses in generalized programs within and outside of the setting in which this study was conducted. This would allow for further investigation of the factors identified as facilitative of or impediments to bereavement visits. The interpretation of these factors needs to be scrutinized and tested further. In addition, public health nurses

with a specialty in bereavement visiting should be included in further studies to explore more thoroughly the role experience plays in bereavement home visiting.

Further research could involve exploring other demographic variables not investigated in this study that could significantly influence public health nurses' perceptions of their abilities to carry out effective bereavement visits, such as attitudes towards death and dying and the influence of bereavement inservice programs. In addition, attempts should be made to identify direct measures of the demographic characteristics of the population, particularly a measure of the effectiveness of the bereavement intervention as well as direct measures of the clarify of values and attitudes and how well the nurse coped with her own personal experience with bereavement.

Finally, the findings from this research should be considered as part of the initial step in an evaluation of a bereavement program. An educational program could be designed to address the factors that impede and facilitate bereavement visiting as identified by the nurses, with the intent of better preparing the nurses to make effective visits. Following from this, after assurance that the nurses do in practice what they have been prepared to do, the bereaved clients could be surveyed to seek their opinion on the effectiveness of the bereavement program.

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APPENDIX I

LETTER TO CONTENT EXPERTS

10728 - 44 Street
Edmonton, Alberta
T6A 1W4
March 26, 1986

Dear

Following our correspondence in February, and your agreement to assist me with my research, "Bereavement Home Visiting: Public Health Nurses' Perceptions", I am enclosing the information and material on which I need your assistance.

You will find enclosed three lists of factors -- cognitive, behavioural, and affective -- that public health nurses may perceive to influence their ability to carry out effective bereavement home visits. I would ask that you examine each item on the lists for clarity. In addition, examine each list for inclusiveness of "essential" content. If any "essential" content is missing, please specify it in the spaces provided. Detailed comments can be enetered in the columns on the right; and I would ask that your "summary" comments be noted on the Summary Critique page.

Your comments and suggestions, along with those of four other content experts, will be carefully considered, the object being to incorporate them into the final form of the questionnaire. The resulting questionnaire will then be pilot tested and revised as necessary prior to the survey itself.

I would also appreciate receiving any constructive criticism which you may wish to offer about the questionnaire format/wording itself (questionnaire attached).

I would ask that the information I have requested of you be returned to me in the enclosed, self-addressed, stamped envelope by April 7, 1986.

I very much appreciate your time and consideration in helping me with my study. Your knowledge and experience in the area of bereavement and your willingness to share your expertise will contribute to the quality of my research.

Thanking you in advance,

Marianne Stewart

Phone: (403) 465-4695 (collect)

APPENDIX II

BACKGROUND INFORMATION OF CONTENT EXPERTS

BACKGROUND INFORMATION OF CONTENT EXPERTS

Ms. B. Brown, B.N.Sc., M.N.

Ms. Brown is an Assistant Professor in the Nursing Faculty at McMaster University. She is also a Clinical Associate with the Hamilton Wentworth Regional Health Unit. Ms. Brown is the Clinical Specialist/Consultant for the bereavement team in the health unit with which she is associated. Ms. Brown developed the training program designed for the public health nurses who are members of the bereavement team responsible for home visits to clients who have recently been bereaved.

Mrs. E. McCutcheon, R.N., B.Sc.N., M.Ed., (Educational Administration), Doctoral Candidate (Educational Administration)

Mrs. McCutcheon is a Certified Psychologist as well as a nurse. Mrs. Cutcheon's Masters Thesis "Comprehensive Care for the Dying -- Organizational Model", endorsed by Kubler-Ross, led to the development of a bereavement program through the Family Services Association of Edmonton, a new and innovative program at that time. The program involved bereavement support groups as well as home visits to the recently bereaved. The prime purpose of the program was one of support and education to the bereaved. Mrs. Cutcheon worked as a Nurse/Psychologist conducting the support groups and home visiting clients on a one-to-one basis.

Ms. D. Spillett, B.Sc.N.

Ms. Spillett is the Senior's Health Nursing Consultant with the Edmonton Local Board of Health. Ms. Spillett has been responsible for this program since 1981.

Ms. Nancy Reeves, B.A. (Child Care), M.A. (Counselling Psychology), Doctoral Candidate (Counselling Psychology)

Ms. Reeves is a Registered Psychologist whose private practice (since 1978) has almost exclusively been counselling people suffering from or about to suffer a loss, a large portion of which was due to a death. In addition, Ms. Reeves does grief counselling at the Queen Alexandra Hospital (Victoria, B.C.), teaches a grief course at the University of Victoria, and conducts workshops on bereavement internationally.

Dr. Bettie Davies, R.N., B.Sc., M.S., (Nursing), Ph.D. (Nursing)

Dr. Davies is an associate professor in the Faculty of Nursing at the University of Alberta. She also holds a joint appointment at the Cross Cancer Institute. Dr. Davies has particular interest and expertise in the area of bereavement, particularly bereavement and children. Her research centered on children's reactions to death of a sibling. Some of her numerous papers and presentations have dealt with coping with loss, care of the dying patient, as well as her specific area of expertise, behavioural responses of children to the death of a sibling.

APPENDIX III

CONTENT LISTS FOR VALIDATION

1. Cognitive

Focus	Comments
a. "normal" process of bereavement.	
b. risk factors associated with abnormal grieving.	
c. "normal", commonly experienced feelings and emotions of the bereaved.	
d. signs and symptoms of abnormal grieving.	
e. cultural differences related to death and dying.	
f. manifestations of grief associated with specific causes of death (e.g. suicide, SIDS).	
g. manifestations of grief associated with specific ages of people who have been bereaved.	
h. psycho-social needs of the bereaved to facilitate the grieving process (e.g. the need of the bereaved to talk about circumstances of the death.	
	Please add any other items which you regard as "essential" to effective bereavement visiting.

2. Behavioral

Focus	Comments
a. communication skills, listening, paraphrasing.	
b. teaching skills.	
c. "checking out" skill.	
d. "emotional safety" skill.	
e. assessment skills of physical, mental, emotional and spiritual health.	
f. skill in coping with <u>your</u> own stress.	
g. skill in conducting a bereavement visit.	
h. skills dealing with client problems related to special cases of bereavement (e.g. suicide, SIDS, etc.).	
i. skill in making initial contact with bereaved.	
j. skill in obtaining entry into the bereaved's home.	
k. skill in deciding when to end your visits to the bereaved client.	
	Please add any other items which you regard as "essential" to effective bereavement visiting.

3. Affective

Focus	Comments
a. age of the deceased:	
- baby/child.	
- geriatric.	
- teenager.	
- adult.	
b. age of the bereaved:	
- geriatric.	
- middle aged.	
- young person with children.	
c. type of death:	
- suicide.	
- chronic illness.	
- sudden/unexpected.	
- accidental.	
- SIDS.	
d. your own experience with bereavement.	
e. your overall nursing skill level.	
f. your overall nursing experience.	
g. your knowledge about bereavement.	
h. the possibility of showing your own emotions during the visit.	
i. clarity of your own values/personal beliefs about death and dying.	

j. the potential to inadvertently be harmful rather than helpful to the bereaved.	
k. the potential to inadvertently invade the client's privacy.	
l. the belief the bereavement visits help the grieving client.	
m. the limited amount of time one can allocate to bereavement visits.	
	Please add any other items which you regard as "essential" to effective bereavement visiting.

APPENDIX IV

TEST QUESTIONNAIRE

Background Information: The following information is needed for categorizing responses in terms of factors relating to age, education and experience, all of which may be necessary to take into account when planning for the bereavement program.

1. Please indicate your age.

- ☐ under 25
- ☐ 25-34
- ☐ 35-44
- ☐ 45-54
- ☐ 55-64
- ☐ 65+

2. How many years of full time and part-time nursing experience do you have?

- ☐ 0-2
- ☐ 3-5
- ☐ 6-10
- ☐ 11-15
- ☐ 16+

3. How many years of full time and part-time experience do you have in public (community) health nursing?

- ☐ 0-2
- ☐ 3-5
- ☐ 6-10
- ☐ 11-15
- ☐ 16+

4. Have you completed both VAP1 and VAP2?

- ☐ yes
- ☐ no (proceed to question 6)

5. What year did you complete VAP 2?

19____

6. Have you made at least one bereavement visit?

- ☐ yes
- ☐ no (proceed to question 9)

7. How many bereavement visits have you made since _____?

- ☐ over 8
- ☐ 5-8
- ☐ 1-4
- ☐ 0 If "0", how long has it been since you made at least one visit? _____

8. How many years have you been doing bereavement visits as part of the ELBH's program?

- ☐ 1 or less
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8

9. Have you experienced bereavement due to the death of someone significant to you?

- ☐ yes, within the last year
- ☐ yes, within 1-2 years
- ☐ yes, more than 2 years ago
- ☐ no

The following questions attempt to determine which cognitive, behavioural and affective factors you perceive to be influential in conducting an effective bereavement visit.

Cognitive:

18a. Please indicate how you would rate the adequacy of your present knowledge in each of the following content areas to carry out bereavement visits.

Key: VA = Very Adequate, A = Adequate, I = Inadequate, VI = Very Inadequate

a. "normal" process of bereavement.	VA	A	I	VI
b. risk factors associated with abnormal grieving.	VA	A	I	VI
c. "normal", commonly experienced feelings and emotions of the bereaved.	VA	A	I	VI
d. signs and symptoms of abnormal grieving.	VA	A	I	VI
e. cultural differences related to death and dying.	VA	A	I	VI
f. manifestations of grief associated with specific causes of death (e.g. suicide, SIDS).	VA	A	I	VI
g. manifestations of grief associated with specific ages of people who have been bereaved.	VA	A	I	VI
h. psycho-social needs of the bereaved to facilitate the grieving process (e.g. the need of the bereaved to talk about circumstances of death).	VA	A	I	VI
i. family dynamics.	VA	A	I	VI

18b. Are there any ADDITIONAL bereavement content areas that you perceive to be important to know?

☐ No. Please proceed to question 11.

☐ Yes. Please list the additional content areas and rate how adequate you perceive your present knowledge to be in relation to those items you list.

_____	VA	A	I	VI
_____				
_____	VA	A	I	VI
_____				
_____	VA	A	I	VI
_____				

Behavioural:

11a. Please indicate how you would rate the adequacy of your present skill level in each of the following areas to carry out an effective bereavement visit.

Key: VA = Very Adequate; A = Adequate; I = Inadequate; VI = Very Inadequate

a. communication skills - listening, paraphrasing. VA A I VI

b. teaching skills. VA A I VI

c. "checking out" skill. VA A I VI

d. "emotional safety" skill. VA A I VI

e. assessment skills of:

- physical health. VA A I VI
- mental health. VA A I VI
- spiritual health. VA A I VI

f. skill in coping with your own stress. VA A I VI

g. overall skill in conducting a bereavement visit. VA A I VI

h. skills dealing with client problems related to special cases of bereavement (e.g. suicide, SIDS, etc.). VA A I VI

i. skill in making initial contact with the bereaved. VA A I VI

j. skill in obtaining entry into the bereaved's home. VA A I VI

k. skill in deciding when to end your follow-up visits to the bereaved client. VA A I VI

11b. Are there any ADDITIONAL types of skills that you perceive as being important to have?

☐ No. Please proceed to question 12.

☐ Yes. Please list any additional types of skills and rate how adequate your skill level is in relation to those items you list.

_____ VA A I VI

_____

_____ VA A I VI

_____

_____ VA A I VI

_____

Affective: The affective factors are divided into 3 groups: situational, personal, and administrative.

12a. Considering your feelings when you make bereavement visits, reference yourself from a neutral position and then indicate whether the following factors would make you feel comfortable or uncomfortable when making bereavement vists.

Key: MC = More Comfortable C = Comfortable U = Uncomfortable MU = More Uncomfortable

Situational

a. age of the deceased:

- baby/child. MC C U MU
- senior. MC C U MU
- teenager. MC C U MU
- adult. MC C U MU

b. age of the bereaved:

- middle aged. MC C U MU
- young person with children. MC C U MU

c. type of death:

- expected. MC C U MU
- unexpected:
  - suicide. MC C U MU
  - accidental. MC C U MU
  - SIDS. MC C U MU

Personal

d. your own experience with bereavement. MC C U MU

e. your overall nursing skill level. MC C U MU

f. your overall nursing experience. MC C U MU

g. your knowledge about bereavement. MC C U MU

h. the possibility of showing your own emotions during the visit. MC C U MU

i. clarity of your own values/personal beliefs about death and dying. MC C U MU

j. the potential to inadvertently be harmful rather than helpful to the bereaved. MC C U MU

k. the potential to inadvertently invade the client's privacy. MC C U MU

Administrative

l. your belief that bereavement visits help the grieving client. MC C U MU

m. the limited amount of time you can allocate to bereavement visits. MC C U MU

12b. Are there any ADDITIONAL factors that make it comfortable or uncomfortable for you to carry out bereavement visits?

☐ No. Please proceed to question 13.

☐ Yes. Please list any additional factors and rate your degree of comfort associated with each item you list.

_____ MC C U MU

_____

_____ MC C U MU

_____

_____ MC C U MU

_____

13a. Overall, given the ELBH program demands and available resources, what relative priority should public health nurses give to bereavement visiting.

☐ High ☐ Medium ☐ Low ☐ No Priority

13b. What overall priority are you actually able to give to bereavement visiting?

☐ High ☐ Medium ☐ Low ☐ No Priority

Why?

_____

_____

_____

_____

7

14. Do you think the clients benefit from having a bereavement visit?

☐ Yes ☐ No

Explain

_____

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15. If you have any further comments you would like to make about bereavement home visiting, please use the space provided below.

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Thank You!

PLEASE INSERT THE COMPLETED QUESTIONNAIRE IN THE ATTACHED SELF-ADDRESSED ENVELOPE AND MAIL IT DIRECTLY TO ME BY . DO NOT PUT YOUR NAME ON THE QUESTIONNAIRE AS THE RESPONSES ARE TO BE TREATED ON AN ANONYMOUS BASIS. THE DATA WILL BE COMPILED AND THE COLLECTIVE RESULTS WILL BE AVAILABLE TO PARTICIPANTS UPON COMPLETION OF THE STUDY.

APPENDIX V

LETTER TO PARTICIPANTS

Letter to Participants

I am a candidate in the Master's of Health Services Administration Program at the University of Alberta. I am conducting a study, entitled "Bereavement Home Visiting: Public Health Nurses' Perceptions", under the supervision of Dr. S. Stinson. The study has been officially endorsed by the Edmonton Local Board of Health, and has been given ethical clearance by the Faculty of Medicine.

My intent in doing this study is to provide information of use in bereavement program planning and evaluation.

As public health nurses are the key personnel involved in the bereavement home visiting program, their perceptions, and those of their supervisors, are of prime importance in program planning and evaluation. The data necessary for this study will be collected from these two groups by means of a mail back questionnaire which will take about 20 minutes to complete.

I would ask you to participate in this study by filling out the questionnaire which will be delivered to you in one weeks' time, through the Board of Health's courier system. The information obtained from your response will be strictly confidential. I will give each questionnaire a code number, but this will be done only to identify the respondent as a staff nurse or supervisor from a specific health centre, to allow for selected cross comparsions. Your participation is, of course, voluntary.

A summary of the findings from this study will be presented to the Management of the Board of Health, and will be made available to all the participants. I look forward to your cooperation and commitment in providing me with the information necessary to proceed with the study. If you require more detailed information about the study, please contact me at 465-4695.

Marianne Stewart
MHSA Candidate
University of Alberta

APPENDIX VI

CRITIQUE OF THE QUESTIONNAIRE

Summary: Critique of the Questionnaire

Your response to the following questions would be greatly appreciated. Your critical comments will be incorporated into the final form of the questionnaire.

1. Clarity.
   Are there any questions which are not clearly stated?

2. Overlap.
   Are there any questions that overlap? If so, which ones?

3. Inclusiveness.
   Is the range of content (cognitive, behavioural, and/or affective) sufficient? If not, what and where are the voids?

4. Did you see question 10 as being intrusive and/or in any way likely to pose a problem for respondents?

5. Did the type of 4 point scale used in questions 11, 12 and 13 present any problems to you? If so, what?

6. From your perspective, is the questionnaire too long?

7. Are the definitions clear and accurate?

8. If you have any further comments regarding the critique of the questionnaire, please elaborate in the space provided below.

APPENDIX VII

QUESTIONNAIRE -- FINAL FORM

INSTRUCTIONS

Please answer all the questions applicable to you as accurately and honestly as possible by selecting the choice which best reflects your opinion, or by writing out a short answer for certain selected questions as indicated.

SURVEY DEFINITIONS

FOR PURPOSES OF THIS STUDY, THE FOLLOWING TERMS ARE SPECIFICALLY DEFINED.

Bereaved Person is someone who is experiencing loss due to the death of a person who is significant to them. This study excludes children (under 20 years of age) who are bereaved.

Checking-Out Skill is a skill which aids the public health nurse in determining how and when to approach the bereaved person. It allows the client to know that the nurse is willing to help and yet she is also respectful of the client's need for privacy.

Emotional Safety Skill is a skill which allows the public health nurse to be emotionally in touch with the bereaved but helps her to maintain the balance between over and under involvement.

Factor refers to any element that a public health nurse perceives as being influential in aiding or impeding making bereavement visits, e.g. elements of knowledge, skills, attitudes, personal qualities, personal experience, administrative policies, proximity of clients to the health centre, etc.

Responder Skills are skills which describe a nurse who is aware that her own beliefs/experience with bereavement influences how she reacts to the bereaved. Taking this into account, the nurse carefully considers the ramification of her immediate reaction to the client as to whether it is appropriate or not, and then respondents in the most helpful manner.

Background Information: The following information is needed for categorizing responses in terms of factors relating to age, education and experience, all of which may be necessary to take into account when planning for the bereavement program.

1. What is your age in years?

   ☐ under 25
   ☐ 25-34
   ☐ 35-44
   ☐ 45-54
   ☐ 55-64
   ☐ 65+

2. How many years of combined full time and part-time nursing experience do you have?

   ☐ 0-2
   ☐ 3-5
   ☐ 6-10
   ☐ 11-15
   ☐ 16+

3. How many years of combined full time and part-time experience do you have in public (community) health nursing?

   ☐ 0-2
   ☐ 3-5
   ☐ 6-10
   ☐ 11-15
   ☐ 16+

4. Please indicate your education status.

   ☐ Diploma
   ☐ Baccalaureate
   ☐ Masters

5. Have you completed <u>both</u> VAP1 and VAP2?

   ☐ yes
   ☐ no (proceed to question 7)

6. What year did you complete VAP 2?

   19____

7. Have you made at least one bereavement visit?

   ☐ yes
   ☐ no

8. Have you experienced bereavement due to the death of someone significant to you?

   ☐ yes, within the last year
   ☐ yes, within 1-2 years
   ☐ yes, more than 2 years ago
   ☐ no

(Over)

The following questions attempt to determine which cognitive, behavioural and affective factors you perceive to be influential for public health nurses to conduct an effective bereavement visit.

Cognitive:

9. Please indicate how you would rate the adequacy of your present knowledge in each of the following content areas to carry out bereavement visits.

Key: VA = Very Adequate I = Inadequate
A = Adequate VI = Very Inadequate

a. "normal" process of bereavement:

- commonly experienced feelings and emotions of the bereaved. VA A I VI

- commonly experienced physical symptoms associated with grieving. VA A I VI

- range of the adjustment period to grief. VA A I VI

b. risk factors associated with abnormal grieving. VA A I VI

c. signs and symptoms of abnormal grieving. VA A I VI

d. cultural differences related to death and dying. VA A I VI

e. manifestations of grief associated with specific causes of death (e.g. suicide, SIDS). VA A I VI

f. manifestations of grief associated with the sex of the bereaved. VA A I VI

g. manifestations of grief associated with specific ages of people who have been bereaved. VA A I VI

h. psycho-social needs of the bereaved to facilitate the grieving process (e.g. the need of the bereaved to talk about circumstances of death). VA A I VI

i. effect of bereavement on family dynamics (e.g. loss of a child on the husband/wife relationship). VA A I VI

j. community resources to which the bereaved clients could be referred. VA A I VI

Behavioural:

18. Please indicate how you would rate the adequacy of public health nurses' present skill level in each of the following areas to carry out an effective bereavement visit.

Key: VA = Very Adequate I = Inadequate
A = Adequate VI = Very Inadequate

a. communication skills - listening, paraphrasing.	VA	A	I	VI
b. teaching skills.	VA	A	I	VI
c. "checking out" skill.	VA	A	I	VI
d. "emotional safety" skill.	VA	A	I	VI
e. "responder" skills.	VA	A	I	VI
f. assessment skills of:				
- physical health.	VA	A	I	VI
- mental health.	VA	A	I	VI
- spiritual health.	VA	A	I	VI
g. skill in assessing suicidal risk.	VA	A	I	VI
h. skill in dealing with the emotions of the bereaved (e.g. anger, depression).	VA	A	I	VI
i. skill in coping with their own stress.	VA	A	I	VI
j. skill in coping with their own feelings about death and bereavement.	VA	A	I	VI
k skill in expressing empathy and caring.	VA	A	I	VI
l. overall skill in conducting a bereavement visit.				
- assessment.	VA	A	I	VI
- planning.	VA	A	I	VI
- intervention.	VA	A	I	VI
- evaluation.	VA	A	I	VI
m. skills dealing with the grieving process associated with special cases of bereavement (e.g. suicide, SIDS, etc.).	VA	A	I	VI
n. skill in making initial contact with the bereaved.	VA	A	I	VI
o. skill in obtaining entry into the bereaved's home.	VA	A	I	VI
p skill in the closure process of the first visit to the client.	VA	A	I	VI
q. skill in planning/making decisions regarding the follow-up visiting needs of the client.	VA	A	I	VI

(Over)

Affective: The affective factors are divided into 3 groups: situational, personal, and administrative.

11. Considering public health nurses' feelings when they make bereavement visits, indicate whether the following factors would make them feel comfortable or uncomfortable when making bereavement vists.

Key: MC = More Comfortable; C = Comfortable; U = Uncomfortable; MU = More Uncomfortable

Situational

a. age of the deceased:

- baby/child. MC C U MU
- senior. MC C U MU
- teenager. MC C U MU
- young adult. MC C U MU
- middle-aged adult. MC C U MU

b. age of the bereaved:

- middle aged adult. MC C U MU
- young adult. MC C U MU
- senior. MC C U MU

c. type of death:

- expected. MC C U MU
- unexpected: MC C U MU
  - suicide. MC C U MU
  - accidental. MC C U MU
  - SIDS. MC C U MU

Personal

d. their own experience with bereavement. MC C U MU

e. their overall nursing skill level. MC C U MU

f. their overall nursing experience. MC C U MU

g. their knowledge about bereavement. MC C U MU

h. the possibility of showing their own emotions during the visit. MC C U MU

i. clarity of their own values/personal beliefs about death and dying. MC C U MU

j. the potential to inadvertently be harmful rather than helpful to the bereaved. MC C U MU

k. the potential to inadvertently invade the client's privacy. MC C U MU

Administrative

l. their belief that bereavement visits help the grieving client.	MC	C	U	MU
m. lack of information on the death notice regarding survivors.	MC	C	U	MU
n. lack of resources to which to refer the clients.	MC	C	U	MU
o. time constraints.				
- the limited amount of time they can allocate to bereavement visits.	MC	C	U	MU
- lack of time to allow them to visit all bereaved clients.	MC	C	U	MU
- lack of time to do adequate follow- up.	MC	C	U	MU

12. Are there any ADDITIONAL factors that are not listed in questions 9, 10, and 11 that you feel are important for public health nurses to carry out effective bereavement visits?
☐ No. Please proceed to question 13.

☐ Yes. Please list any additional factors in the space provided below.

_____

_____

_____

_____

_____

_____

13a. Overall, given the ELBH program demands and available resources, what relative priority should public health nurses give to bereavement visiting.

☐ High ☐ Medium ☐ Low ☐ No Priority

13b. What overall priority are they actually able to give to bereavement visiting?

☐ High ☐ Medium ☐ Low ☐ No Priority

Why?

_____

_____

_____

_____

(Over)

14. Do you think the clients benefit from having a bereavement visit?

☐ Yes ☐ No

Explain

_____

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15. If you have any further comments you would like to make about bereavement home visiting, please use the space provided below.

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Thank You!

PLEASE INSERT THE COMPLETED QUESTIONNAIRE IN THE ATTACHED SELF-ADDRESSED ENVELOPE AND MAIL IT DIRECTLY TO ME BY JUNE 18,1986. DO NOT PUT YOUR NAME ON THE QUESTIONNAIRE AS THE RESPONSES ARE TO BE TREATED ON AN ANONYMOUS BASIS. THE DATA WILL BE COMPILED AND THE COLLECTIVE RESULTS WILL BE AVAILABLE TO PARTICIPANTS UPON COMPLETION OF THE STUDY.